WHAT SHALL ONE GIVE IN EXCHANGE FOR ONE'S SOUL: SPIRITUALITY IN THE HEALTHCARE SETTING

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ABSTRACT

WHAT SHALL ONE GIVE IN EXCHANGE FOR ONE'S SOUL:

SPIRITUALITY IN THE HEALTHCARE SETTING

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The current environment in healthcare is at a crossroads regarding the understanding of the role spirituality plays in the dynamic of physical healing. Although there is evidence to support the importance of the spiritual and religious lives of patients, it is difficult for members of the medical and nursing staff to make the time to learn more about the care of the soul. Hospital chaplains work within this healthcare environment to advocate for the spiritual needs of patients and to assess and meet those needs. It is also their role to offer the healthcare team their expertise in the area of spiritual and religious diversity. As healthcare continues to advance, and as healthcare providers seek to integrate a more biopsychosocial model of patient care, it is the responsibility of professional spiritual care providers to ensure important spiritual elements are included within patient care plans and staff education programs.

This demonstration project revolved around a course I developed called *The Soul of Healing*, which comprises three teaching sessions with accompanying PowerPoint presentations. Since I am a Supervisor in the Association for Clinical Pastoral Education, I first trained the residents in the Clinical Pastoral Education program, and then had them train nursing staff on one of their assigned patient care units at a designated medical center in the southwestern United States.

My demonstration project revealed that education alone is insufficient to transform the role of spiritual care in interdisciplinary relationships, but personal relationships during times of crisis seems to have a positive impact.

To my husband, Charles Pritz, for his unfailing affirmation, encouragement, and his critical editorial eye. He has been a source of soul support and healing for me during the past two years.

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INTRODUCTION

WHAT SHALL ONE GIVE IN EXCHANGE FOR ONE'S SOUL?

What gives life meaning? This question sends people in many different directions in order to find an answer. Jesus asked this question in a different form. He asked his disciples to ponder the value of their life and soul. "Those who want to save their life will lose it, and those who lose their life for my sake will find it. For what will it profit them if they gain the whole world but forfeit their life? Or what will they give in exchange for their life? (Matthew 16:25-26)[1] An equally valid translation of Jesus' question would be "What will it profit them if they gain the whole world but forfeit their *soul*? Or what would they give in exchange for their *soul?*" since the Greek word ψυχη can mean either life or soul. This passage indicates that it is within our soul that we find the meaning for our lives. Without our soul, life loses its meaning and purpose. Our soul is our very life.

There are a multitude of diversions that would keep us alienated from our soul. "We live in a culture that discourages us from paying attention to the soul or true self – and when we fail to pay attention, we end up living soulless lives."[2] At the same time,

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[1] All biblical quotes, unless otherwise noted, are from the New Revised Standard Version.

[2] Parker J. Palmer, *A Hidden Wholeness, the Journey Toward an Undivided Life: Welcoming the Soul and Weaving Community in a Wounded World* (San Francisco: Jossey-Bass, 2004), 34-5.

there is present in many people a deep longing for a connection with ones' self, with others, and with God. In the hospital setting, where people must confront their own mortality, there is the chance to stop, reassess, and discover how to make space for the soul.

Medical science is beginning to recognize the importance of the inner life of people for optimal healing. Some physicians are sufficiently bold as to call for spiritual practices to nurture the individual during the time of recovery. Others acknowledge that an individual's state of mind has an impact on the response to medical interventions. Benson extensively researched the impact of stress upon the human body and ways to minimize that impact.

> Recently, researchers studying the long term effects of the fight-or-flight response have concluded that it (the flight or flight response) may lead to permanent, harmful physiological changes. … The stressors of modern living elicit it at times when it is inappropriate for us to run or fight. We must find ways to control the harmful aspects of this primitive psychological response and so neutralize the negative effects of modern stress on our health and well-being. The relaxation response can do just that.[3]

Weil considers spiritual practice as a distinctive and essential element of health and healing. He gives spiritual practices as a prescription in his healing plan. Some of the disciplines he recommends are to practice deep breathing, appreciate the beauty of nature, participate in meditation, honor the reality of the spiritual aspect of life (or as I have identified it, the soul), enjoy the beauty of uplifting music, practice fasting, seek forgiveness and reconciliation, and extend compassion and acts of kindness to others.[4]

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[3] Herbert Benson and Eileen Stuart, *The Wellness Book, The Comprehensive Guide to Maintaining and Treating Stress-Related Illness* (New York: Simon & Schuster, Fireside, 1993), 34.

[4] Andrew Weil, Eight *Weeks to Optimal Health* (New York: Ballantine Publishing Group, 1998), 171-2. Dr. Weil discusses a plan to address many of the causes of health problems by incorporating diet,

Much of Weil's plan is not new to followers of Jesus, who calls us to participate in acts of healing for others and for ourselves. Even the world of science is discovering the benefit of tending to the soul.[5]

Since we can demonstrate the powerful impact of taking care of one's self through attention to the inner life, why is it such a challenge for those who are ill and for their caregivers to make this a priority? To explore some of the resistance to the concept of integral healing (where the physical, emotional, spiritual, and communal needs of the person are addressed), it is important to understand how the historical, philosophical, and sociological split between the soul and science came about. A review of the history of medicine and faith provides an understanding of the uneasy alliance between these two essential ways of knowing truth. During the pre-modern and modern eras, we experienced reality as a dichotomy between objective and subjective truth. In the modern era, objective truth and the scientific method came into ascendancy.

The hospital is a monument to the modern era and to the scientific method. Within the hospital, the scientific method brought about unprecedented growth in the knowledge of the human body and diseases. It has remarkably increased the human life span in developed countries. This knowledge, however, has come at a high price as objective truth has obscured the subjective experience for patients and caregivers alike.

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exercise, and spiritual and mental activities. The practices listed above were included in the final phase of his eight-week plan.

[5] Paul S. Mueller, David J. Plevak, and Theresa A. Rummans, "Religious Involvement, Spirituality, and Medicine: Implications for Clinical Practice," *Mayo Clinic Proceedings* 76 (December 2001): 1226. The authors documented studies that demonstrated the positive impact of spiritual practice in the healing process and encouraged physicians to become more active in attending to the religious activities of their patients.

> In our quest to free knowledge from the tangles of subjectivity, we have broken the knower loose from the web of life itself. The modern divorce of the knower and the known has led to the collapse of community and accountability between the knowing self and the known world.[6]

The hospital continues to be a place where care and support for the sick and injured are offered. The legacy of compassionate care, which was born in the healing ministry of the early church, is still alive. The advances in the scientific knowledge of disease processes and the increased dependency upon technology have led to a diminishing of that legacy. Within the confines of the hospital, hope exists for a reunion of faith and science. Chaplains and Clinical Pastoral Education students can take the initiative to engage hospital staff in our mutual task to facilitate healing. We have the challenge and opportunity to work together as an integral healing team to bring about a new type of hospital where all are engaged in the task of regaining the soul of healing.

Challenge Statement

There is evidence that the healing process is significantly enhanced when spiritual care and medicine work together. At the designated medical center in the southwestern United States, Clinical Pastoral Education students and hospital nursing staff have opportunities to work together and learn from each other. Within this context, I developed three teaching sessions with accompanying PowerPoint presentations for the education of CPE students and nurses. Through education and training, both disciplines are able to improve interpersonal communication, interdisciplinary cooperation, and come to an increased awareness of spiritual, cultural, and religious diversity.

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[6] Parker J. Palmer, *To Know as We Are Known: Education as a Spiritual Journey* (San Francisco: HarperCollins Publishers, 1993), 26.

CHAPTER I: THE SETTING

General Setting

In the past twenty years, medical researchers have explored the impact that faith has upon healing as well as the effect of a variety of ancient and alternative healing methods.[7] As science becomes more aware of the direct physiological impact of spiritual practices and beliefs on recovery, many medical schools and hospitals are beginning to take a serious look at patients' religious beliefs and practices and their affect on healing.[8] As scientists discovered the cure for various diseases, they also discovered that the patient's state of mind and belief system made a significant contribution to their ability to heal, the rate of healing, and mortality rates.

The current healthcare environment is in a state of transition and there continues to be conflicting perspectives on the role of one's spiritual life upon their health. Even among those who accept that one's spiritual life is an important element of healthcare,

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[7] Harold G. Keonig, "Religion, Spirituality, and Medicine: Research Findings and Implications for Clinical Practice," *Southern Medical Journal 97* (December 2004): 1194-1200.

[8] Auguste H. Fortin and Katherine Gergen Barnett, "Medical School Curricula in Spirituality and Medicine," *Journal of the American Medical Association* 291 (June 16, 2004): 2883. The authors document the rise in medical school curricula that incorporates some way to look at the spiritual needs of patients.

there is significant anxiety regarding how the staff of the hospital should address the spiritual needs of patients.[9]

Hospital chaplains work within this healthcare environment to advocate for the spiritual needs of patients and to assess and address those needs. As healthcare moves forward and as healthcare providers seek to integrate a biopsychosocial model of care, it is the responsibility of the spiritual care providers to ensure that the spiritual elements are not dropped by the wayside.

Chaplains, and those who train them, frequently relate concerns about how spiritual care is perceived in hospitals across the country. While there are chaplains who are well integrated into the healthcare team, many others find themselves marginalized and in constant danger of being targeted in budget cuts because their departments are seen as a nonessential function. It is important that chaplains, CPE students, and their supervisors take some responsibility to educate staff and continually advocate for integrated care.

As healthcare moves further into the twenty-first century, the role of technology and the financial pressures on hospital systems pose a challenge for caregivers to continue to honor the intangible soul. They must work intentionally to uphold a loving response to the whole human being.[10] The denial of the importance (or even the

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[9] Daniel P. Sulmasy, "A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life," *The Gerontologist* 42, Special Issue III, (2002): 24-33. The author relates a variety of reasons why medical professionals have difficulty adequately addressing the spiritual needs of patients and evaluates some of the tools that are available for addressing those needs.

[10] Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York: Oxford University Press, 1999), 685. The author related the history of hospitals and noted how hospitals have lost the personal element as they have become increasingly technical. He wondered about the damaging effect of such depersonalized care of patient well-being.

existence) of the soul is cause for concern in the medical world. This demonstration project is an attempt to introduce a prophetic voice into the hospital community and advocate for the spiritual life and needs of patients.

We are at a point in history where there is openness to the role of the soul in the healing process.[11] Medical professionals are interested in the physical implications of prayer and spiritual practice in healing. At the same time, it is extremely difficult to include training about spiritual and cultural needs within medical and nursing curricula that are highly complex and becoming more so all the time. It is important to educate medical professionals about the importance of the inner life of their patients, and to provide a means whereby they can effectively interface with the chaplains and CPE students in addressing the whole patient in the healing process.

Specific Setting: A Teaching Hospital in the Southwest

The medical center where this demonstration project took place is part of a healthcare system with hospitals in seven states in the western United States. The designated hospital is the largest hospital in the system, is a quaternary care center, meaning that it deals with the most serious cases, and has the most specialized care. This hospital is a level-one trauma center located in the urban heart of a major city in the

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[11] Harold Koenig, Michael McCullough, and David Larson, *Handbook of Religion and Health* (New York: Oxford University Press 2001), 437-448. In this book, the authors present a meta-analysis of the studies that were done on the effects of religious practice upon a variety of diseases. Although not all studies demonstrated a positive effect, many others showed a statistically significant positive impact for the role of religion in improving patient outcomes in some situations. They encourage further studies and offer ideas about how the religious and healthcare communities can move forward to enhance the healthy role of spiritual care toward the sick.

southwest and has 700 beds. The hospital offers specialized care in ten different areas including, an Alzheimer's center, oncology, cardiology, high-risk obstetrics, neurology, orthopedics, rehabilitation, kidney, liver, and bone marrow transplants, and in-patient psychiatric care.

The hospital is a major training site and has residents in Graduate Medical Education and Clinical Pastoral Education. There are also students in nursing, physical therapy, occupational therapy, and music therapy. There is a commitment to education at multiple levels as a means to stay on the cutting edge of medicine and healthcare.

This medical center serves a diverse population, including a large number of Hispanics, Native Americans, and African Americans. Additionally, because of the desert climate and the presence of a large university nearby, this city is home to immigrants from Africa, Arabic countries, India, Pakistan, and parts of Asia. These populations add to the religious and cultural diversity of the community.

The Association for Clinical Pastoral Education accredits this hospital to offer Clinical Pastoral Education at all three levels: Level I, Level II, and Supervisory CPE. The director of the Department of Spiritual Care and is an ACPE Supervisor. The author of this dissertation was formerly employed as an ACPE Supervisor within the hospital where she served as the primary faculty for Clinical Pastoral Education. The current CPE program has six full time residents, six students in extended CPE, and one student in supervisory education. During the fall unit, there were seven residents. One resident graduated in December of 2007.

Focus Situation: Fall 2007 - Residency Unit

The spiritual needs of patients can be addressed when those who care for them are aware of the importance of addressing the emotional, spiritual, and cultural aspects of the patient in their healing. Those spiritual care providers who work closest to the patients are ideally suited to educate hospital staff about these aspects of patient care. In order to equip the CPE residents to offer the necessary education, I developed a training program consisting of three teaching modules, each lasting approximately fifteen minutes. These teaching modules gave the CPE students the opportunity to take an active role in providing the necessary education.

Through this project, I wanted to improve the knowledge base of CPE students and nursing staff alike. I accomplished this, by educating the CPE residents regarding sensitivity to the needs of the patient. I taught them to recognize the spiritual, religious, and cultural diversity of patients. Additionally, I equipped them with the necessary tools to teach what they had learned to nurses on a designated unit by developing teaching modules for them. I hoped to improve the students' pastoral role and professional relationships as members of a multidisciplinary team by having them teach what they had learned. Although most of the students were able to offer the training and were confident of their role on the patient care areas, the interdisciplinary collaboration was not realized.

CHAPTER II: POLITICAL AND ORGANIZATIONAL ASPECTS

The hospital where this demonstration took place, like all other hospitals, is a political organization. Department directors seek to obtain whatever financial and human resources they believe they will need in order to fulfill their assigned tasks and continue to stay in the good graces of the administration. Administrators direct and focus the overall effort while simultaneously competing with the other hospitals within the system and with the other healthcare systems throughout the country in their efforts to remain successful and financially stable. When it comes to navigating the political organization, spiritual care providers do well when they heed the words of Jesus according to Matthew 10:16: *See I am sending you out like sheep into the midst of the wolves; so be wise as serpents and innocent as doves*. God calls chaplains to be effective advocates for the spiritual needs of patients, their families, and staff members; and they are called to advocate for those spiritual care programs that serve to enhance our pastoral calling to honor the needs of the soul within the hospital setting.

Political and organizational features serving to promote integrated healthcare

At the medical center, a number of factors serve to promote integrated healthcare. Last year the hospital converted to an electronic charting system. This charting system, *Cerner Millennium*, features a variety of interdisciplinary sections where each discipline can document their patient visits. When patients are admitted, their primary nurse

determines their need for interdisciplinary attention using a standardized admission interview. Then the computer sends out automatic referrals to every discipline that is required to care for the needs of the patient. Throughout the day, the Spiritual Care Department receives these *Cerner*-generated referrals, which provide an efficient way for chaplains and CPE students to focus their ministry. They can devote their time to those patients who requested a chaplain or whose nurses, physicians, or social workers believe would benefit from receiving spiritual care. Chaplains and CPE students then document their patient visits by not only completing a standardized spiritual assessment but also recording their visits on a separate form designed to facilitate communication between the various disciplines.

Another way the hospital administration facilitates integrated healthcare is through the Language and Cultural Services Department. This department offers in-house interpreters for patients whose first language is Spanish (about thirty percent of the patient population). These interpreters not only allow patients to understand the medical information they are receiving but also allow medical teams to gain insight into the cultural concerns of their patients. Spanish-speaking patients may also feel less isolated when they know someone is on their side and is advocating for their needs.

The Spiritual Care Department also seeks to meet the spiritual and cultural needs of the Hispanic population by offering a bilingual CPE program to promote and facilitate the development of professional Spanish-speaking chaplains. Through this bilingual training program, the Spiritual Care Department seeks to provide voices for those without a voice and advocates for those who may be feeling helpless in the face of racial

prejudice. This may change, however, with the recent cut in funding for the bi-lingual CPE program.

Political and organizational features inhibiting integrated healthcare

While the hospital's electronic medical record system makes patient information available in real time to all who may require it, staff members must also spend significantly more time entering that information. Recently a hospital administrator visited one of the patient care units and noticed everyone was at the computers and no one was with the patients. The demand for detailed documentation, while certainly important, minimizes the time available for staff to interact with patients and their families. The electronic records system also increases the potential for practitioners of the various disciplines to spend more time interacting with electronic charts and less time interacting with other staff as they seek to learn of the needs of specific patients. Finally, because electronic records are standardized, much that is unique about each patient may not be included on the chart and may, therefore, not be considered during the development of specific patient healthcare plans.

Every department is required to coordinate their procedures and tasks with the initiatives and measures established by the Board of Directors for the system. Of the fourteen people comprising this Board, two are physicians, two are lawyers, and ten are from the business sector. Such a representative mix tends to produce a focus that is financially driven. The Board, in consultation with the executive leadership develops initiatives for the system that directs the quality improvement efforts for each hospital and department. Recent initiatives included improved efficiency in performing routine medical tasks, increased the effectiveness of specific surgical procedures, and more

accurate checking of patient armbands. There is always one initiative related to meeting the financial target set by the Board. Such initiatives seek to improve financial stability, compliance with federal guidelines, patient safety, and customer satisfaction (as measured by *NCR Picker*, a standardized questionnaire). The Spiritual Care Department generates no revenue; therefore, there is little the department can do to help meet financial targets. The only measure the Spiritual Care Department can realistically influence is the Customer Satisfaction Questionnaire. Because the questionnaire includes no measure of how poorly or how well hospital staff honored and addressed the spiritual and cultural needs of the patient, the Spiritual Care Department occupies one of the more vulnerable positions within the hospital's political and organizational structures. Consequently, the temptation is for Spiritual Care to go for quantity rather than quality, to move away from seeking to fulfill the spiritual and cultural needs of fewer patients in order visit as many patients as possible.

Political and organizational features encouraging a "silo" mentality

The hospital has 700 patient beds, seven medical specialties, and ten intensive care units. This hospital is also a major teaching medical center where physicians, nurses, chaplains, and a variety of other healthcare professionals can come and fulfill both internship and residency requirements. Though such educational diversity does provide excellent teaching and learning opportunities for a wide variety of healthcare professionals, it also has negative consequences: the promotion of an organizational "silo" mentality. I believe both patients and staff suffer the consequences of such an organizational atmosphere in two primary ways.

First, continual supervision and training of healthcare students tends to narrow the focus of those who are teaching to their own areas of expertise. This dynamic promotes intra-disciplinary learning at the expense of interdisciplinary learning. Because most healthcare professionals today become specialists and few become general practitioners, the holistic needs of patients are rarely addressed.

Second, specialized patient care units naturally attract the most suitable personality types. Such specialties tend to develop group identities that promote attitudes of exclusivity. While this can foster team cohesion, it can also result in the dismissal of professionals from other disciplines as outsiders. This tends to render effective interdisciplinary communication difficult at best and nonexistent at worst. Again, it is the patients' holistic needs that tend to suffer the consequences of poor interdisciplinary communication.

A proposal to address barriers to integrated healthcare

Members of the Spiritual Care Department can take several steps to participate in creating a healing hospital. One easy step is for chaplains to offer the spiritual gift of hospitality to staff on the units where they serve. Chaplains and CPE students can welcome new employees and encourage the chaplain-staff relationship that is at the heart of integrated healthcare. This means that chaplains have to take the initiative to engage the staff rather than passively waiting for the staff to come to them. As chaplains attend to the emotional and spiritual needs of the staff, the staff will have a better idea of how to make use of spiritual care for their patients.

Chaplains can also facilitate interdisciplinary relationships by engaging in personal conversations with nurses and physicians regarding the patients' spiritual and

emotional needs. It is through these personal connections that the chaplains will become visible presences of the floors, bringing in their being the value of the spiritual and emotional concerns of patients into integrated care. As chaplains discuss the spiritual concerns of patients and relate how they attempted to meet those needs, hospital staff will start to see how these concerns impact other aspects of the patients care.

In is also important for the Spiritual Care Department to continue to make opportunities to offer formal educational activities about areas related to their areas of expertise. As they participate in educational fairs and teaching workshops on cultural and religious diversity or spiritual and emotional needs they can continue to advance awareness of our role in healthcare.

Like most political systems, relationships are the primary way to introduce and bring about change. There is sufficient evidence that spiritual care is an important aspect of patient care but it is up to the chaplains to take the initiative to demonstrate its importance through active participation in patient care and active dialogue with other members of the hospital staff.

CHAPTER III: ECCONOMIC ASPECTS

The system where this demonstration project took place, including the specific medical center, is a not-for-profit healthcare system. The system is concerned with maintaining its financial security. Every year there is considerable discussion concerning the economic aspect of healthcare and the ability of the system to continue competing successfully in the United States hospital industry. Employees are under a continual mandate to help the organization meet its annual financial targets. Hospitals within the system that do not meet their financial targets are penalized and cannot receive capitol funds as long as they continue to under perform. Departments that chronically under perform financially are often discontinued. Such unrelenting pressure to perform creates a tense ministry environment. I believe most United States hospital Spiritual Care Departments are experiencing similar economic circumstances.

Economic factors affecting the practice of healthcare

Within the narrow timeframe of this demonstration project, the state in which this project took place went through a number of disruptive economic changes, including the rapid collapse of a once-thriving real estate market and an emotional environment which (due to the passage of new employee-hiring state legislation) became more hostile than ever toward people of Hispanic origin. Meanwhile healthcare continues its struggle to contain costs while simultaneously remaining competitive through increased

specialization and investments in the latest hospital equipment and diagnostic technology. At the same time, the hospital, like many other hospitals throughout the country, continually attempted to reduce its overhead. Due to current economic circumstances, the Clinical Pastoral Education remains under intense scrutiny to determine if, in the opinion of the hospital administration, the department is indeed a profitable enough financial asset.

This deteriorating economic situation is especially difficult on the Hispanic population. Many are looking for people to crucify for the economic downturn and are blaming those Hispanics who are living and working in the United States illegally. There are intense political efforts to punish undocumented aliens by denying them healthcare and education. This acrimonious situation brings out latent racial hostilities in some hospital staff. Although official hospital policy forbids it, some Hispanic patients are not offered all of the services of the hospital, including spiritual care. Recently one of the chaplains had to advocate insistently for the comfort cart (a hospital cart loaded with free coffee and cookies) to be brought around for the family of a dying Hispanic patient.

Several months ago, in order to meet the streamlined 2008 budget, hospital administration asked the Spiritual Care Department to make employee cuts. This resulted in the Hispanic bilingual CPE program losing funding. Since bilingual CPE students are no longer compensated, many Hispanics can no longer afford to receive chaplaincy training and education. This may also mean the cultural and spiritual needs of many Hispanic patients will not be met. This termination of bilingual CPE program funding definitely limits the capacity to attract promising Hispanic students into the ministry of

hospital chaplaincy, thus further restricting both the quality and the quantity of future pastoral care that can be offered on behalf of Hispanic patients and staff.

Economic advantages to addressing the spiritual needs of patients

The Joint Commission for the Accreditation of Hospital Organizations (JCAHO) requires all hospitals to provide some means for adequately addressing patient spiritual needs. Maintaining accreditation with JCAHO is financially crucial because without national accreditation a hospital cannot receive Medicare and Medicaid funds. Providing for the spiritual needs of patients creates a clear economic advantage for every hospital in the United States.

A number of studies have clearly demonstrated how spiritual care improves patient outcomes. "Health outcomes can be positively affected by attempts to address emotional and psychosocial needs. Two studies note positive physiological responses resulting from the emotional comfort of spirituality."[12] Through ensuring patients have access to professionally trained and qualified spiritual care providers, hospitals can offer patients their best chances for full recovery from injury, illness, and disease.

Additionally, when compared with other professional disciplines, professional chaplains are extremely cost effective.

> Spiritual care provided by chaplains is cost effective. The only published chaplaincy cost study reported the services of professional chaplains range between $2.71 and $6.43 per patient visit. Additionally, approximately three quarters of

[12] Paul Alexander Clark, Maxwell Drain, and Mary P. Malone, "Addressing Patients' Emotional and Spiritual Needs," *Joint Commission Journal of Quality and Safety* 29 (December 2003): 661.

> HMO executives surveyed reported that if spirituality can have an impact on wellbeing, then it can helpfully impact cost containment.[13]

Of course, hiring professional chaplains and offering accredited CPE programs represent more costly alternatives to using unpaid volunteers or minimally-trained staff in an attempt to provide for the spiritual needs of patients and staff. However, unskilled spiritual caregivers often cause the kind of harm professional chaplains have been trained to avoid. A different hospital within the healthcare system had an elderly Jewish patient who was dying. A volunteer chaplain told that patient to accept Jesus as his Savior or he would go to Hell. Such insensitivity to the religious and spiritual needs of this patient triggered a significant complaint by the man's spouse. Had she chosen to do so, she could have sued the hospital. Instead, she and her family vowed never again to patronize any system facility. This is but one example of the actual and potential damage that may be done when a hospital chooses not to invest in professionally trained chaplains.

The hospital where this project took place employs a combination of professional chaplains and CPE students to provide for the spiritual needs of patients, their families, and staff members. The chaplains and CPE supervisory staff are salaried, and five CPE residents earn a reduced salary. These five full-time residents, who are in class ten hours a week, do the work of four full-time chaplains for the price of three full-time chaplains. Though our five part-time CPE students work the equivalent of two full-time chaplains, they are not financially compensated. In addition, one full-time CPE resident and one

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[13] Larry VandeCreek and Laurel Burton, eds. "Professional Chaplaincy: Its Role and Importance in Healthcare," Whitepaper by The Association for Clinical Pastoral Education, The Association of Professional Chaplains, The Canadian Association for Pastoral Practice and Education, The National Association of Catholic Chaplains, and The National Association of Jewish Chaplains. (2001): 17.

part-time CPE student perform their clinical work within off-site patient care facilities which pay the hospital placement fees. These placement fees are equal to the salary of one full-time chaplain. Clearly, a CPE program may both greatly enhance the quality of spiritual care provided by a hospital and also be an economic bargain.

I believe recognizing and serving the spiritual needs of patients, families, and staff is a sacred task. Though it represents a significant investment to employ professional chaplains and offer professional CPE programs, when hospital administrations consider their bottom lines, investing in professionally-staffed spiritual care departments and an accredited CPE program makes perfect economic sense.

CHAPTER IV: CULTURAL ASPECTS

This demonstration project had as one of its goal to provide an educational format to raise the cultural awareness of the CPE students and hospital staff. In order to facilitate their understanding of cultural differences, I had each of them tell stories about their lives so that they could appreciate the cultural diversity that was present among themselves first.

The major participants in this project included CPE residents in the first unit of a year-long residency program. The group consisted of seven students, six women and one man. The cultural and religious diversity of the group broke down in the following way.. There was one African-American woman in her late forties. Her husband was a military chaplain and she was ordained in the full gospel tradition. She and her husband have three adopted children in their late teens and early twenties. Her oldest daughter has a baby during the unit. There was one Filipina woman. She was recently married and was in her late forties. She is a former Roman Catholic nun. Her husband is a French expatriate. Many of this student's extended family life within a few blocks of each other in a Phoenix suburb. All other students were Caucasian. The lone male in the group was a married man in his mid fifties. He was in his second marriage. He had a son and a daughter with his first wife; the son died in an automobile accident about ten years ago. He has a school-aged son with his second wife. He is considering ordination in the Evangelical Lutheran Church in America. There was also a single woman her early

fifties, who was ordained in the ELCA and had served for several years in Japan and China. Another woman was married and in her early sixties with four grown children. She was a parish nurse and was an active member of the Methodist church. One other woman in the group was in her early forties and was married to a psychiatrist who works for the VA system. She has one daughter, and she was ordained in the United Church of Christ during the unit. The final student was a woman who was in her third marriage. She was a practitioner in the Science of the Mind religion. The supervisor of the unit is a married Caucasian woman in her mid-fifties with no children. She is ordained in the Christian Church (Disciples of Christ) and is an ACPE Supervisor.

The CPE students provided ministry in a large inner-city hospital that serves a diverse population. The county where the hospital is located breaks down into this demographic: of White, not Hispanic 61.5% , Hispanic, 29%, Black, Native American 2.2%, and Asian, 2.7%. [14] The patient population has a higher percentage of Native Americans and African Americans than the county population would indicate. With the makeup of their peer group and the diversity of the population they served, they were thrust into the midst of diversity from the beginning.

As their supervisor, I addressed the cultural aspects of the education in two distinct ways, by facilitating the interaction and relationships between students themselves, between students and other members of the spiritual care department, between students and staff, and between students and patients and families. Through the "living human document' students can begin to understand the complexities of human interactions in a multitude of areas, cultural diversity being only one.

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[14] People Map Stats, (Maricopa County, Ariz.) [database online]; available from http:// www.fedstats.gov.

Student Education

Since I worked with the CPE students over an extended time and had the responsibility for their education throughout the implementation phase of this demonstration project, I had the opportunity to give them a much broader education than was available through the *Soul of Healing* teaching modules. As the students became acquainted with each other, they were able to discover the different ways they looked at things like: definition of family, how to navigate conflict, the appropriate way to show emotions, and how to say no. This recognition of their cultural differences took place throughout the unit.

I scheduled one of the staff chaplains, a Hispanic woman from Mexico, to lead two cultural didactic sessions for them. One dealt with pastoral care to Hispanic patients and touched upon the salient features to keep in mind when working with this population. The other was a didactic to give them an understanding about the plight of undocumented people, their reasons for immigrating and the struggles they face with exploitation and abuse. This gave the students a deeper appreciation for a significant but marginalized population.

I also scheduled the chaplain from a local Native American hospital to come and speak to the students. She talked about the different tribes that are in the state and gave an overview of the major health concerns this diverse population faces. She then gave some general guidelines about how to interact respectfully with Native American patients, specifically the elderly.

Using *The Soul of Healing* Training Module

The primary resource I used for teaching the cultural diversity training module was *Pastoral Counseling Across Cultures*[15] I made use of Augsburger's spectrum of cultural awareness as a way to explore one's attitude toward diversity. Within the limited time-frame of the training module, I determined that this would be more useful than trying to give specifics about cultural groups. I wanted to avoid an overly simplified view of cultural diversity and avoid creating more stereotypical perspectives. My intention for the presentation was to encourage cultural sensitivity toward those with different value systems and beliefs. Augsburger described several levels of cultural openness in the following ways:

Cultural Encapsulation is the state of mind where one is not aware that others have different ways of doing things. There may be a sense of cultural superiority in this stance, but often one who is culturally encapsulated is not aware that there are other value systems

Cultural Awareness is the state of awareness where one recognizes that others have different customs, holidays, family structures, and ways of accomplishing tasks. Recognizing different value systems does not mean that one abandons their own value system in favor of another. There is a logical structure supporting a different cultural expression and one can appreciate the difference

Cultural Sensitivity is the level of awareness where one begins to take an active role to understand and respect those with different backgrounds. When working with a

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[15] David W. Augsburger, *Pastoral Counseling Across Culture* (Philadelphia: Westminster Press, 1986), 13-47

patient or family from a different culture, the culturally sensitive caregiver looks for ways to allow the patient to be as comfortable as possible in the strange culture of the hospital.

Cultural Competence is an ideal toward which to strive. It is the ability to see the situation from another person's perspective. This requires one to pay close attention to the unique characteristics of a patient and their family and listen as they tell us about their experiences.

The last part of the session offered some suggestions about how those of us who are giving care to someone from a different culture can be effective and treat others with respect. Those ways include:

- Recognize one's own religious and cultural assumptions
- Expect that others have different assumptions and experiences
- Take an attitude of a student and let the patient teach you
- Remember that you have common ground
- Recognize the value of cultural patterns
- Avoid stereotypical generalizations about members of a cultural group

The session concluded with areas requiring cultural sensitivity for staff to keep in mind as they worked with patients and families:

- Family structure – decision making
- Sense of personal space
- How to talk with those outside of the family (including eye contact, volume of speech, questions, interruptions, who can talk with those in authority)
- How to address major life transitions
- Dietary and hygiene needs

It was my hope that the CPE students would feel comfortable offering the *The Soul of Healing: Awareness of Religious and Cultural Diversity* workshop. I also wanted it to contain useful information and serve to make those involved more sensitive to the needs of those from different cultures and give them a comfort level that would encourage them to engage others with relative ease.

CHAPTER V: METHODOLOGY

The *Soul of Healing* sessions were the result of the evolution of three previous versions. The first version was offered to the CPE resident group in the spring of 2007. The second version was offered to the 2007 summer students from two hospitals within the healthcare system. The third version was given to OB/GYN residents late in the summer of 2007. I wanted to use a developmental model to demonstrate how conceptual structures are formed across different religious and cultural traditions. I was not able to find a way to simplify the information sufficiently to fit within the time limits of this project. I also found that several CPE students had a strong reaction to a developmental model because they perceived a prejudice against the foundational levels. I wanted the students to be comfortable teaching the training sessions, so I looked for a simple and effective way to communicate about spiritual and cultural issues in order to improve patient care in these areas.

Choosing Content

In designing the *Soul of Healing* teaching modules, I wanted to develop material that would have the greatest impact in a short time. With that in mind, I decided to start by addressing the need to listen and attend to the other. *Encountering the Soul* was an attempt to articulate the pastoral skill of "presence". Recognizing that most CPE students do not start out knowing how to listen well, I was confident that hospital staff would find

it useful to learn about or be reminded of the importance of slowing down and making time to listen to patients. "When we really make the time to soul listen and hear others, we send the message to them that they are important, loved, and valued by us."[16] I decided to develop something to allow students and staff alike to use simple techniques to honor their own souls and to attend to the soul of others. This became the foundational to the entire *Soul of Healing* series.

After I settled on the content for the first module, I developed an outline for the remaining two modules. *Awareness of Spiritual Diversity* intended to address the spiritual life of patients in a non-sectarian way. I thought it would be easier to engage students and easier for them to engage the staff around the some common ways people experience their spirituality rather than leading off with the topic of religious differences. After identifying some of the ways people experience transcendence, I offered some tangible things that staff or chaplains could do to assist patients in connecting with their sense of God based upon the patient's way of experiencing their spiritual life. Wilber's spiritual states formed the theoretical basis for the presentation.[17]

The final training module was *Awareness of Religious and Cultural Diversity*. I intended to introduce the variety of religions in the world as a way to expand staff and student awareness. I included some non-organized religious expressions so that they

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[16] Cari Jackson, *The Gift to Listen, The Courage to Hear (*Minneapolis, Minn.: Augsburg Books, 2003), 3.

[17] Ken Wilber, *Integral Spirituality: A Startling New Role for Religion in the Modern and Postmodern World* (Boston: Integral Books, 2006), 50-102. Wilber draws upon developmental understanding to propose that individuals have several lines of development and that they develop spiritually through stage somewhat along the lines of James Fowler's stages of faith development. Wilber also identifies four spiritual states that are temporary and experiential peak experiences that can be cultivated through spiritual practice. The spiritual states are: nature mysticism, deity mysticism (personal relationship with God), formless mysticism (as in meditation) and non-dual mysticism (union with God).

would realize that not all religious groups are recognized as such. I drew upon Augsburger's spectrum of cultural openness to provide a frame of reference for examining one's own comfort level with diversity.[18] I also included some simple guidelines for working with patients and families from different cultures and religious backgrounds.

Use of CPE Process

Long before the students began their teaching staff on their assigned patient care units, they had to learn the things that they were going to teach. Because the teaching modules incorporated some basic pastoral skills, I was able to use parts of the CPE curriculum to equip the students with the required skills. The needs of the demonstration project fit in well with the learning needs of the CPE students. Because they were all adult learners, I wanted to make use of their own experience and responses to the course content through encouraging self-reflection and discussion.

Before students could teach staff to encounter the soul of the patient, they first had to encounter their own souls. I used several CPE teaching activities to help the students in that area. When the CPE unit started, I invited them to share the spiritual journey that brought them to the current place and time using a creative medium. By encouraging them to access their story through collage, song, or painting, I created a non-threatening way for them to access their soul and share with others on their own terms. I also assigned the Jackson text as a way to stimulate self-observation so that they could discover ways in which they were open to the souls of patients and ways in which they

[18] Augsburger, 26.

were closed. Discussion of the book and reviewing verbatim accounts through the text provided a frame of reference for recognizing their progress with soul listening and spiritual presence. I also modeled soul listening for them during our individual supervisory sessions.

A large part of the CPE process is the use of the community as a source of learning. Within the group, students directly encounter diversity and their degree of tolerance for difference. As they navigated the cultural, racial, religious, and personality type differences among themselves and within the Spiritual Care department, they discovered hidden biases and assumptions that blocked them from authentic community. "In discussions, students can serve as critical mirrors for each other, reflecting the assumptions they see in each other's positions."[19] Their growing ability to communicate effectively and trust one another made it easier for them to engage in relationships with patients and staff who were different from them. In addition to their personal experiences, I scheduled several speakers to address areas of diversity and I led a few sessions.[20] I also led the group discussions during verbatim sessions and interpersonal relationship seminars where students were able to experiment with different communication styles.

The assigned reading and speakers taught the students the skills that they would need in their ministry and for their teaching experience. CPE draws upon an educational model where students immediately apply what they learn in their ministry and then

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[19] Stephen D. Brookfield and Stephen Preskill, *Discussion as a Way of Teaching: Tools and Techniques for Democratic Classroom* (San Francisco: Jossey-Bass, 2005), 25.

[20] See Orientation Schedule and Fall Unit Schedule, Appendix C.

reflect on the outcome so that the learning is quickly into the student's ministry. Within a few days of arriving on campus, students were initiating pastoral visits, making spiritual assessments, making spiritual interventions, and encountering a wide diversity of patients. They performed their ministry with increasing skills in active listening, assessing, and addressing spiritual needs.

Before the students taught the modules on their designated units, I walked them through each module. With the first module, I demonstrated how to set up the laptop/projector combination. I then showed the PowerPoint presentation and facilitated discussion around content and presentation. Each segment of the *Soul of Healing* series was shown separately. Once all modules had been viewed and discussed, I incorporated the changes recommended by the students and made CD with the modules and other pertinent information required to set up and teach the sessions. I asked each student individually if they needed any additional support or information in order teach the presentations, but they all indicated that they had all of the information and support that they needed.

During the six weeks of the *Soul of Healing* project, the students kept a record of their interdisciplinary interactions with staff on the unit where they offered the training by responding to six questions.[21] Three questions asked for the number of staff referrals, staff visits, and staff consults they had on the designated unit. Each of these measures were part of the student's daily records, they had easy access to these statistics. Two questions asked the students to assess their level of comfort with staff and with their interdisciplinary role on the unit. One question asked about the student perception of

[21] See Appendix D.

staff awareness of the role of the spiritual care on the unit. I collected these surveys at the end of the project.

As part of the training modules, the students gave the staff who participated in the sessions a brief evaluation form to discover if the information had been useful to the staff. Each student's surveys were grouped together with staff evaluations of the project so that I could correlate student and staff changes together.

CHAPTER VI: THEOLOGICAL THESES

I approached this demonstration project as a hospital chaplain and Association for Clinical Pastoral Education (ACPE) Supervisor immersed in a world far removed from academia. My understanding of the world was colored by daily exposure to human weakness as seen in devastating physical illness and serious injury inflicted through carelessness, greed, or cruelty. It is a harsh world that values preserving physical life and which only addresses the soul as it might serve the needs of the physical body. In a small corner of a large, inner-city hospital, I met several times a week with Clinical Pastoral Education (CPE) students to seek ways to learn from our front line experiences as spiritual caregivers and soul-listeners. We met at the interface between life and death to explore how God might fit into that picture. We also sought to discover how best to care for those souls whose broken bodies were in the hospital for healing. Several theological issues cried out for further exploration, with most of them revolving around the value of the human soul and the importance of the work of our small community of chaplains and CPE students who sought to advocate for the care of the souls and spirits of patients, staff members, and ourselves.

Considering Matthew 16:24-26 from the Perspective of Hospital Ministry

Jesus said to his disciples:

> If any want to become my followers, let them deny themselves and take up their cross and follow me. For those who want to save their ψυχην will lose it, and

> those who lose their ψυχην for my sake will find it. What will it profit them if they gain the whole world but forfeit their ψυχην? Or what will they give in return for their ψυχην?

As used in this passage, the Greek term ψυχη refers to "the seat and center of the inner human life in its many varied aspects"[22] and "as the seat and center of life that transcends the earthly."[23] In other words, ψυχη refers to the soul itself, as well as to that deep inner life that endures after we die. From early in the history of Christian theology, the soul has been understood as one of the three aspects of human existence (body and spirit being the other two).[24] In traditional evangelical circles, this passage has been used to call people to accept Jesus into their heart and be "saved." By accepting Jesus, people will not "lose their soul." Other theologians have asserted Jesus was advocating the priority of the soul over the body; and some have even interpreted this passage to support the argument that views the human body as worthless.

From my perspective, the gospel writer gives us Jesus' admonition about following after transitory things at the expense of the soul as a way to affirm the importance of the inner life rather than as a condemnation of the physical body. Jesus seemed to place ultimate value on the soul, and he indicated that those who neglected their own soul did so at their peril. We must choose whether to cultivate the inner life of our soul or pursue the preservation of our physical existence to the detriment of our inner spiritual life. The way of life that Jesus proposed is one that honors the life of the soul

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[22] Fredrick William Danker, ed., *A Greek-English Lexicon of the New Testament and other Early Christian Literature*, rev 3d ed. (Chicago: The University of Chicago Press, 2000), 1099.

[23] Ibid.

[24] Serene Jones and Paul Lakeland, eds., *Constructive Theology, A Contemporary Approach to Classical Themes (*Minneapolis, Minn.: Fortress Press, 2005), 86.

and condemns an exclusive focus upon temporal existence. Rather than denigrating the body, Matthew 16:24-26 encourages me to honor the needs of my soul by taking the time to care for it.

Jesus warned his disciples not to follow him if they wanted to cling to their temporal existence, and to follow him only if they realized the eternal value of their soul. Perhaps because I have served a physically oriented healing community for so long, Jesus' questions have taken on far greater personal significance than I could ever have imagined otherwise.

Throughout this demonstration project, my students and I struggled to advocate for the souls of patients and staff and to preserve our own souls in the midst of a setting which tends either to deny the soul altogether or to pay only lip service to its value. Many patients encounter their own souls for the first time when their life is threatened by serious illness or accident. When visiting hours are over, the physicians and the nurses have completed their tasks, and patients are alone and awake in the middle of the night, many discover that they have neglected their soul. Some want to find a way to tend to their intangible selves and look to spiritual caregivers to help them find a way to reintegrate their souls back into their lives. Others seek forgiveness and need assurance that God still loves and accepts them. Some are motivated to reconcile with those they have wronged or with those who have wronged them. Others respond by retrenching themselves in denial.

Life tends to take on a different meaning after one has witnessed the harsh reality of death for the first time. My CPE students and I offered ministry in the shadow of death every day. We developed a deep appreciation for the fleeting and uncertain reality

of life. From this vantage point, we advocated for the needs of the soul and for the care of the soul as the one aspect of our humanity that survives death. The purpose of my demonstration project was for it to serve the cause of soul-advocacy. Every day God called us not only to remember the importance of the soul but also to remind our hospital community that nothing can be given in return for it.

The Physical Consequences of Neglecting the Soul

The questions Jesus posed are relevant to our society today. Everywhere we look, it seems we have indeed forfeited our soul in exchange for a frantic pace of life that increasingly is threatening to destroy our very existence. In the hospital setting, the focal point is necessarily upon saving the life of the patient; but most often, that means saving only the biological life of the person who is in their care. Modern science has become adept at saving and preserving our biological life. If our Gospel passage refers to biological life alone, then contemporary healthcare is doing a good job. If we understand it to mean our soul as well as our physical existence, then contemporary healthcare is doing a poor job. "Contemporary medicine still stands justly accused of having failed to address itself to the needs of whole human persons, and of preferring to limit its attention to the finitude of human bodies"[25]

In the United States, many impersonal factors are conspiring against the human soul today. We live in a pervasive atmosphere of materialism in which the need to produce and consume exerts an excessive influence upon our existence. The tyranny of productivity increasingly puts a strain on the human capacity to multitask, resulting in

[25] Sulmasy, 24.

stress-related illness and chronic sleep deprivation. The social status and worth of a human being is directly related to his or her capacity to work competitively, be productive, and contribute to the financial wellbeing of the companies for which they labor. Top executives of many companies pay lip service to being concerned for the women and men who help them become successful, but then are quick to eliminate jobs and increase the workload of their remaining employees. In healthcare, the focus remains almost exclusively upon those cutting-edge technological, surgical, and diagnostic procedures that have the greatest potential to cure physical illnesses but also tend to ignore the human beings upon whom those procedures are performed. All of these impersonal factors are significant contributors to stress and adversely affect health.

> As many as half the premature deaths in the United States may be due to unhealthy behaviors or lifestyles….of the ten leading causes of premature death, at least seven could be substantially reduced if Americans altered their bad habits. These include poor diet, smoking, lack of exercise, alcohol abuse, and *unhealthy responses to tension and stress* (italics mine).[26]

Jesus rightly calls us to become aware of the peril of gaining the whole world while neglecting our own soul. Fortunately, he also offers us a way to transcend our self-destructive responses and behaviors.

The Role of Community in Healing

Parker Palmer has written a book to help his readers discover the importance of the soul and develop practices to nurture and support their own soul. He understands that much of the hollowness people in contemporary society experience is in response to a lack of support for and nurture of the soul. "We live in a culture that discourages us from

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[26] Benson, 12.

paying attention to the soul or true self – and when we fail to pay attention, we end up living soulless lives."[27] Palmer believes it is essential to transcend our cultural norms and discover ways to care for the soul. He advocates for regularly taking time to listen for and hear from our own soul. He also advocates for the establishment of an intentional community as the best environment for honoring and nurturing our soul and encouraging it to speak the truth to us.

CPE has the potential to become just such an intentional community where the souls of students and supervisors may be both restored and renewed. Every morning in the classroom, the CPE community gathered to pray and to debrief the previous night's events. I remember one of my students talking about a terrible on-call the night before. Two gangs had engaged in warfare and five young people had been brought into the trauma room with gunshot wounds. This student's most troubling event was a young woman who had been inadvertently shot in the head while driving through the warring neighborhood. His soul was deeply wounded by such senseless violence and by this innocent young woman's life, which had been so randomly cut short. Our CPE group became a sacred space for him as he shared his pain and confusion about where God was in this tragedy. He also questioned why he had to witness the carnage of such senseless gang violence. Though we had no answers for him, in respectful silence we heard and honored his painful story. When the student had finished, we lifted him up in silent prayer and then again in verbal prayer. Within our community of soul-listeners he discovered a sacred place where he could come to some measure of peace through having his unanswerable questions both heard and honored.

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[27] Palmer, *A Hidden Wholeness*, 34-35.

Through this demonstration project, I wanted to form a community where the souls of my CPE students would be both honored and supported. We regularly met and prayed together and shared the lessons we were learning through patients and staff members and each other, and we created a sacred space where we could discover how it was going with each other. As we created the space to hear one another, we became the kind of intentional community that could both remember and reclaim souls. The students gained enough strength from these encounters to enter the nursing units, where chaos and stress reign every day, and calmly attempt to advocate and care for the soul.

Care of the Soul in the Midst of Diversity

In the hospital environment we tend to discover what is real about God and faith and the soul, and what are little more than plausible ideas about God. Many of my conventional religious ideas disintegrated within that crucible of unrelenting human suffering. As I worked with people of different faiths, I discovered many of them possessed vital spiritual lives and souls that were more highly developed than many of the Christians I had ever known. For me, ministry within the hospital environment represented both a call and a challenge to expand my understanding and cultivate a more inclusive hermeneutic of God.

Soares-Prabhu addresses this need for a broader spiritual perspective. He encourages all thoughtful spiritual pilgrims to recognize "all reality as an interconnected, interrelated, and interdependent whole."[28] He offers a hermeneutic that invites all

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[28] George M. Soares-Prabhu, "Laughing at Idols: The Dark Side of Biblical Monotheism (an Indian Reading of Isaiah 44:9-20)," from *Reading from This Place,* vol. 2, *Social Location and Biblical Interpretation in Global Perspective,* Fernando Segovia and Mary Ann Tolbert, eds. (Minneapolis, Minn.: Fortress Press, 1995), 112.

Christians to strive for a higher level of inclusivity: "God's concern cannot be monopolized by a single people but must reach out to all. God's all-pervasive presence cannot be restricted to any one temple or to any one 'holy' land but must encompass the world."[29] CPE is practiced within a multi-faith and multi-cultural setting that requires spiritual care to be offered from a perspective of greater inclusivity. We are all children of God and we are all endowed with a soul; and, therefore, all authentic efforts to know, love, and serve God must be embraced as having validity. Aslan, the Christ figure in Lewis' *The Last Battle*, said:

> "If any (one) swear by Tash and keep (the) oath for the oath's sake, it is by me that (one) has truly sworn, though (s/he) knew it not, and it is I who reward (that one). And if any (one) do a cruelty in my name, then though (s/he) says the name Aslan, it is Tash whom (s/he) serves and by Tash (the) deed is accepted."[30]

For this Christian author, service to God is service to God, even if that service is manifested under a false understanding of God. It is the intent and the action that indicate whether our worship, scriptures, values and way of life originate in the soul, and whether or not the One True God is being truly served. I believe the God who is the True Creator and the True First Source, cannot be the sole property of any exclusive community of worshippers.

Soares-Prabhu also says, "For the Indian reader, what lends a touch of irony to this anti-idol polemic of the Bible is the perception that what makes the biblical authors so prone to see and condemn idolatry in others is the element of idolatry in their own

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[29] Soares-Prabhu, 126.

[30] C.S. Lewis, *The Last Battle: Book 7 in the Chronicles of Narnia* (New York: Collier Books, 1978), 165.

religion."[31] Psychology teaches us about the shadow side of human nature and the tendency to see and hate in others those very traits that are most active in and most hidden from one's own self. Here Soares-Prabhu is challenging the proprietary claim that many Christian denominations place on God and Truth. In order to honor all living souls, therefore, we must be aware of the all-too-human tendency toward idolatry within our own hearts and be willing to sacrifice our own idols before we may ever hope to discover the One True Living God.

Within any urban hospital setting, CPE students engage in dialogue with many different religious traditions. Encounters with individuals who come from different belief settings often prove threatening to many students. In order to offer effective ministry, they must find a way to enter into the sacred space of those who do not share their view of God. Many students are tempted to transport others into their own spiritual reality, but attempts to do this often result in a violation of the soul of those others. Their challenge is to allow the other to speak from their own soul and discover those places of spiritual connection and community. The possibility always exists for such encounters to change forever a CPE student's understanding of God.

My own soul crisis came about through encounters with other belief systems. They threatened my ground of theological understanding. I often wondered if my faith would remain strong enough to sustain the impact of such unsettling spiritual encounters. Ultimately, my original concepts about God had to undergo a radical transformation. In order for my soul to survive, I had to make a real leap of faith. If I allowed my presuppositions about God to die, would I ever regain my soul – or would it remain lost

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[31] Soares-Prabhu, 125.

to me forever? I thank God that I can wholeheartedly affirm the Truth of Jesus' words. By allowing my smaller soul to die, I gained a larger soul that continues to thrive within the broader context of the world. I gained this larger soul through realizing my images of God were symbols for a greater Truth than can ever be adequately expressed in mere human language or grasped through mere human imagery. I tried to walk with every one of my CPE students as they walked the path where their embedded theological beliefs were challenged through encountering the souls of others within the mysterious depths of their own soul.

As one attempts to interpret the Bible from within the context of an urban hospital, many factors can shape one's hermeneutic. Daily exposure to birth, death, violence, disease, and all manner of human suffering demands an interpretation of scripture that holds true in real life. Using Matthew 16:24-26 as our foundational theological text, we explored the relevance of this scripture within the hospital setting. The life of the soul both deserves and demands our undivided attention. Accumulation of stress depletes the soul and causes physical and emotional distress. Stress may be alleviated by caring for the soul through intentional spiritual practices and disciplines. The soul may be both heard and nurtured through participation in an intentional spiritual community that creates and upholds a sacred space for the soul.

What can one give in exchange for one's own soul? I believe nothing is more precious in life than the soul. The soul, however, requires constant our care and nurture if we want to withstand the overwhelming pressures and corrosive forces of modern secular life. I believe when we make the time to care for our own soul, then it shall sustain us through the worst hardships this life has to offer.

CHAPTER VII: BIBLICAL BASIS

In order to look at faith and its relationship to healing, it is important to see what the biblical accounts of healing have to teach us. From the healing ministry of Jesus, we get a clear picture of integral healing which involves all aspects of a person. An examination of a few of the healing stories in the gospels will give us a perspective on several ways in which Jesus healed.

The scriptures often correlate illness with broken relationships, with God or with others. Jesus sometimes extended forgiveness as part of the overall healing process:

> Just then some people were carrying a paralyzed man lying on a bed. When Jesus saw their faith, he said to the paralytic, "Take heart, son, your sins are forgiven." Then some of the scribes said to themselves, "This man is blaspheming." But Jesus, perceiving their thoughts said, "Why do you think evil in your hearts? For which is easier to say, 'Your sins are forgiven?' or to say, 'Stand up and walk'? But so that you may know that the Son of Man has authority on earth to forgive sins" – he then said to the paralytic – "Stand up, take your bed and go home." And he stood up and went home. (Matthew 9:2-7)

Like some of the Jewish people in this passage, many mainline Christians feel uncomfortable with Jesus connecting healing in relationship to the forgiveness of sin, partly because we do not focus on sin much anymore and partly because Divine punishment by illness is at odds with our contemporary understanding of God's love. While I do appreciate our movement away from a perspective that interprets illness as being God's punishment for sin, I also believe some illnesses are the result of lifestyle choices people make. Research reveals as much as half of all disease is a direct result of

lifestyle choices.[32] Some patients interpret illness as punishment; but many, when they are being very honest with themselves, admit their physical problems are the consequences of their own behavior. I am specifically thinking of gang members who come into the hospital as a result of gang violence, and people who have long-abused their bodies with addictive substances. In these and many other cases, the person will not be healed – even though the physical damage may be successfully treated. Unless those patients' souls are addressed, they will end up back in the unhealthy situation. As patients with injured souls confront themselves and seek reconciliation and restoration, they can find healing for their whole being and experience the release from guilt that forgiveness brings. Forgiveness brings about healing from broken relationships that can foster the actual physical recovery. "Healing relationships, emotional pain, and the sense of isolation that is at the root of much human disease is a necessary step in helping the healing system perform most efficiently."[33]

Hospitalized people often believe they are ill because of sin committed in the past. Some fear their illness is due to moral failure rather than their healthy lifestyle choices. The chaplain can sometimes help set a sick person free by simply acknowledging the person's fear that God is punishing them. Chaplains can facilitate processes of life review and self-examination to help patients seek forgiveness or explore areas where they need to make amends in order to allow healing to take place. In these situations, chaplains can facilitate the healing process and can encourage the patient to make important lifestyle changes.

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[32] Benson, 12.

[33] Weil, 161.

Many times, however, the disease process is rooted in purely physiological causes. Our bodies are susceptible to a wide variety of bacteria, viruses, and genetic malfunctions. We are vulnerable to many diseases that have no relationship to personal moral failure or lifestyle choices. Under these circumstances, the chaplain can offer prayer and be an empathetic, supportive presence.

> As he walked along, he saw a man blind from birth. His disciples asked him, "Rabbi, who sinned, this man or his parents, that he was born blind?" Jesus answered, "Neither this man nor his parents sinned; he was born blind so that God's works might be revealed in him (John 9:1-3).

From this passage, we see Jesus clearly understood there was not a direct correlation between the disease process and sin. He introduced a new paradigm: afflictions sometimes happen as opportunities for us to see and experience God's desire to restore us and bring about our healing. The ministry of Jesus demonstrated such healing is available for all manner of illnesses, for men and women alike, and for children as well as adults. Contrary to the Hebrew Scriptures, where the major emphasis is upon isolating from the social and religious community those people who become sick and persist in their uncleanliness, Jesus emphasizes God's desire to restore, through compassionate acts of holistic healing, all who have been summarily judged and condemned and cast out of society.

In the hospital setting, chaplains can assist patients through understanding how conditions of illness and health are complex responses from our existence as biological, psychological, social, and spiritual human organisms. Disruption within any one of these human realities affects the wellbeing of all the others. "But illness disrupts more than relationships inside the human organism. It disrupts families, and workplaces. It shatters preexisting patterns of coping. It raises questions about one's relationship with the

transcendent."[34] As we better understand the profound interactions between our aspects of wellness, we better understand the contributions to healing spiritual care provides by facilitating the renewal and restoration of the emotional and spiritual wellbeing of the patient. In other words, spiritual care providers are better understood as being active agents of healing.

Sometimes, in order to become the active agents of healing that God calls us to be, we must first confront those structures and institutions that are standing in the way of holistic healing. Chaplains in the United States are called to minister within a society that tends to deny the existence of the soul, and we are called to work within healthcare systems that rarely recognize the need to care for the soul.

> Jesus left that place and entered their synagogue; a man was there with a withered hand, and they asked him, "Is it lawful to cure on the Sabbath?" so that they might accuse him. He said to them, "Suppose one of you has only one sheep and it falls into a pit on the Sabbath; will you not lay hold of it and lift it out? How much more valuable is a human being than a sheep! So it is lawful to do good on the Sabbath." Then he said to the man, "Stretch out your hand." He stretched it out, and it was restored, as sound as the other. But the Pharisees went out and conspired against him, how to destroy him (Matthew 12:9-14).

In many instances, Jesus' healing activities were a direct challenge to the Hebrew system of belief. He confronted the ways in which Hebrew Law was being used to punish the ill, and he condemned those religious leaders who looked to that Law as a means to justify their lack of compassion for the suffering of the afflicted. Jesus established a new understanding of illness, both from a physical and from a spiritual perspective. He established a new precedent that defined the Christian Church and our Christian attitude toward those who become sick. We too are called to show compassion

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[34] Sulmasy, 26.

for the sick and afflicted and do whatever we can to help restore them to physical, emotional, spiritual, and communal wholeness.

Chaplains can affirm Jesus' direct challenge to the barriers to compassionate healing through actively incarnating his loving care for the sick. Incarnating such a prophetic paradigm, however, also requires that we confront and challenge the status quo whenever and wherever the medical community is not recognizing the need to care for the soul. One of the chaplain's most important roles is to affirm and model the need for compassion through becoming a vocal advocate for the patient. Chaplains also need to remember to keep their own hearts soft in order to be that compassionate presence which can foster an atmosphere of holistic healing within the hospital room. "A Sacred Encounter occurs whenever we meet another's deep need with a loving response. Our responses may be intuitive, but love always assumes authentic expression."[35]

Healing is a multi-faceted reality. The role of chaplaincy does not address only one aspect of healing: it permeates all of our healing aspects with a subtle and persistent reminder that we are indeed spiritual beings, that our bodies and souls are integrally interwoven. If one aspect of a person becomes afflicted with illness or disease, then the whole person becomes afflicted. Chaplains are not only called to faithfully incarnate Jesus' model of compassionate healing, but we are also called to transform our hospitals through calling and encouraging everyone to participate in compassionate, integral healing.

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[35] Erie Chapman, *Radical Loving Care: Building the Healing Hospital in America* (Nashville, Tenn.: Baptist Healing Hospital Trust, 2003), 58.

CHAPTER VIII: SPIRITUAL RESPONSE

Before I began this demonstration project, I was primarily a spiritual being. I entered ministry because my highest value is for the life of the soul, for my own connection with God. After more than twenty years of hospital ministry, I have experienced first-hand the difficult challenge of maintaining focus on the soul while trying to navigate the scientific world that focuses so intensely upon the physicality of life. This demonstration project focused me even more acutely upon the tension between my own spiritual life and the world's frenetic activity that would shift my focus away from my soul. In my proposal, as a reminder to care for my soul during the development and implementation of the demonstration project, I posed three research questions regarding the spiritual life.

Use of Spiritual Practices to Address Stress

My personal spiritual practice during the life of this demonstration project included daily meditation and prayer. My meditation began with a specific time set aside to quiet my mind so that I could release any mental chaos and reconnect with my core of inner peace. I made use of techniques from centering prayer, breath meditation, guided imagery, and listening to music designed to induce a meditative mental state. Such meditation practices allowed me to cope with living and working in a highly stressful urban environment while pursuing this Doctor of Ministry degree. My prayer times are

when I engage in dialogue with God through my thoughts, through journaling, or through reading scripture or a spiritually mature text which inspires me to look at life in an ever-deeper way. Often I find prayer and meditation become interwoven in a kind of intricate dance between stillness and inner dialogue. It continues to be my experience that "there is no way to stay in touch with one's soul and keep a balance there, outside of regular private prayer."[36]

Another facet of my personal spiritual practice takes place in relationships. As I engage in thoughtful conversation with my husband, students, colleagues and friends, I begin to perceive answers to some of my inner struggles and receive support and encouragement. My husband is a continual source of this support and encouragement. Sometimes he reminds me to stop working and go for a walk or do a yoga routine. He lets me get in touch with my fear and anxiety and allows me to express myself without trying to give me rational reasons not to feel that way … well, most of the time anyway.

At the beginning of 2007, my husband and I were led to change our worshipping community. We realized we needed a more heart-centered pastor and church family to help us make it through the challenges of the coming year. We made the right choice. My current pastor would come by my office and offer both encouragement and prayers. I came to realize that I could not accomplish this journey by myself. Within the context of my relationships, I receive empowerment to explore the challenges of my spiritual life: needing to forgive and be forgiven, confronting the truth about my own shadow-self, and risking rejection by holding another accountable to their higher self. Developing my

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[36] Ronald Rolheiser, *The Holy Longing; The Search for a Christian Spirituality* (New York: Doubleday, 1999), 218.

spiritual life within the contexts of relationship and community continues to be the best of times and the worst of times. Faithful community is essential to the ongoing journey of spiritual growth.

During this project, I received support for my spiritual life through a number of occasions to rest and allow my body and spirit to be renewed and refreshed. My husband and I took several weekend trips to a remote mountain cabin to remove ourselves from the business and distractions of work and studies. We also committed to regular exercise, practiced yoga daily, and ate a balanced vegetarian diet. Such ongoing lifestyle commitments help me maintain a healthy body and spirit. My own experience confirms Benson's conclusion that, during times of increased stress, a healthy physical, emotional, and spiritual life is essential to personal health.[37]

The Spiritual Life of Chaplains and Openness to Other's Spiritual Needs

Clinical Pastoral Education affirms that our emotional and spiritual states of being are directly related to the way we engage patients. If we are wrestling with certain aspects of our relationship with God, then we cannot be of much help to someone with similar struggles unless we acknowledge our own difficulties first. The experiences of the resident group who participated in my demonstration project confirmed they were emotionally and spiritually open to patients to the same degree that they were emotionally and spiritually open to themselves.

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[37]Benson, 33.

CPE students at the hospital offer ministry within what might best be termed a war zone. In order to address the spiritual needs of patients in such a hospital environment, they must also attend to their own souls. Throughout this project, I individually supervised each student on a regular basis. I explored with them the challenges they face and how well or poorly they were attending to their own spiritual life. It is, of course, the student's own responsibility to maintain private spiritual practices, but I also played a role in encouraging and supporting them in this aspect of their existence.

A large part of the chaplain residency experience involves engaging their souls in relationship with each other. In the group process, students receive support and encouragement while they are struggling with the secondary trauma of seeing broken bodies in the trauma room or witnessing the cancer death of a young mother. Peer support and prayers are healing experiences that help them recover and be strengthened and renewed.

In addition to being a place of support, the peer group is where the hard work of spiritual growth may take place. Students review their ministry with patients, families, staff, and benefit from those diverse perspectives regarding their own strengths and areas for growth. They face the challenges of hearing truths they would rather not hear and speaking truths they would rather not speak. They also have the opportunity to strengthen their own souls through extending and receiving forgiveness. Through the hard work of spiritual growth, they are able to become more effective ministers and enlarge their souls so that they are better able to withstand the stresses of their pastoral calling.

As chaplaincy students are sustained, nurtured, and challenged in their own spiritual lives, they become better able to assess the spiritual lives of patients and their families. During times of illness, patients and families are frequently open to spiritual care and many actively seek it. Students may assess their spiritual lives and assist in their healing in several ways. Simply giving the patient or family member their full attention can become a profound act of spiritual care. "To truly listen to a person who is undergoing any loss is one of the greatest gifts a caregiver can impart … Listening affirms our commitment to care and invites people out of their isolation and into community."[38] Chaplains can also initiate meaningful interventions and help people by praying with them, offering communion, facilitating guided imagery, or other spiritual disciplines designed to strengthen our connection with God during times of illness.

Improving Cooperation between Chaplains and Medical Staff

I developed the three *Soul of Healing* modules so that chaplaincy students could teach members of the hospital staff to recognize and honor the spiritual lives of their patients, and to improve communication between hospital staff and patients. Many hospital personnel are aware of studies demonstrating the effectiveness of meditation on reducing stress and inducing the relaxation response. "By learning to use your awareness and your mind, you can begin to control your physical reaction to stress." [39] Most of them, however, do not apply such knowledge to their care of patients. The three teaching

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[38] Butler, Sarah A., *Caring Ministry: A Contemplative Approach to Pastoral Care* (New York: Continuum Publishing, 2000), 30.

[39]Benson, 33.

modules proposed certain ways hospital staff could improve patient care through the recognition and honoring of their spiritual needs.

The first module specifically invited caregivers to slow down when they were with a patient, listen carefully to their concerns, ask questions to be sure their spiritual needs were being honored, and respect their personal dignity. Through this demonstration project I learned most hospital staff did not know how to care for the souls of their patients. On the staff evaluations, the most commonly-cited new thing learned was the importance of listening to their patients and taking the time to honor them as real persons. I was encouraged that a majority of those who participated in the three *Soul of Healing* modules felt "somewhat comfortable" or "very comfortable" applying what they had learned to their work.

Through this demonstration project, it has become clear to me that reclaiming the soul starts within each individual caregiver and then radiates outward into the broader care-giving community. With so much competing for our attention, it is easy to lose sight of our own spiritual life. If attending to the soul is a valid indication of a healthy spiritual life, then I believe we are experiencing an epidemic of sick souls. Healing is possible and chaplains have an important role is ending that epidemic. The more we attend to our own soul through prayer and meditation, the more we nurture authentic relationships and develop community, the more we become able to honor and nurture the souls of others with our loving and compassionate presence.

CHAPTER IX: COMPARABLE MINISTRIES

As I investigated what other hospitals and CPE centers were doing to teach spiritual and cultural diversity, I found the most common tool was a workshop or a seminar. These were 1-2 hour presentations, typically given by chaplains as part of their CPE program or as an educational opportunity for the staff or community. Several CPE centers brought in speakers from different cultural and religious groups, and some took their students to visit places of worship within different religious traditions. I do integrate similar events into the student residency year, but those experiences are not designed for students to share with medical staff.

Many spiritual care programs around the United States have developed some way to educate hospital staff about spirituality and cultural and religious diversity. Rev. Sue Wintz and Rev. Earl Cooper developed a course, *Cultural and Spiritual Sensitivity,* to teach hospital staff about cultural differences and heighten their awareness regarding important religious and spiritual differences. Their *Cultural and Spiritual Sensitivity* course involves several self-examinations to reveal and explore one's own cultural presuppositions and biases. It also utilizes scenarios involving various culturally or religiously laden difficulties to engage the student's critical thinking. It then provides practical suggestions for the avoidance of cultural conflicts.

This course is a regular part of staff orientation in the hospitals where the authors work. All new employees must complete it within their probationary period. It is often

self-taught through a workbook, but it may also be taught in the classroom setting. Wintz and Cooper require anyone who uses this course to use it in its entirety. The course is thorough and well-packaged. The Association of Professional Chaplains published this program and made it available to its members.

The information in the *Cultural and Spiritual Sensitivity* course is quite useful, but it does lack the interpersonal engagement that is an important element in *The Soul of Healing* teaching modules. I believe there is ample room for both approaches to such education. Within the hectic atmosphere of the contemporary hospital setting, providing courses that may be taken within one's personal work schedule certainly does have merit.

I was unable to find another training program that included the CPE students as a major component of its methodology. I believe the quality of CPE student education was improved by asking them to assume the role of educator on their floors. If I were to implement this project on a hospital-wide scale, I would look for ways to weave together the classroom experience with an in-depth online course and see how well that might work to improve interdisciplinary communication and relationships.

CHAPTER X: TRANSFORMATION

My intention for this demonstration project was for it to be a step toward a more complete integration of spiritual and emotional patient care into existing healthcare paradigms. I am certainly not a pioneer here, as others have long recognized this gap in contemporary healthcare.

> Until the late nineteenth century, the mind was regarded as inseparable from the body, but as science gained dominance, dualism began to pervade medical thinking. The mind was sundered from the body and seemed a thing apart, a spiritual rather than a scientific entity.[40]

For many years, researchers have been investigating the impact of the soul on the patient's capacity to heal. Although those who flatly deny the healing power of faith upon one's physical health still exist, the evidence continues to mount that caring for the soul has a significant effect upon a person's wellbeing. I began with the assumption that medical staff would be more inclined to include spiritual care in the plans of care for their patients once they became cognizant of its true importance. I was hoping that offering such spiritual education in several smaller segments would help them integrate care for the soul into routine medical practice and thus realize a more integrated approach to patient care.

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[40] Bernard Lown, *The Lost Art of Healing* (New York: Houghton Mifflin, 1996), 29-30.

Personal Transformation

I began this demonstration project with the realization that there was a kind of spiritual disconnection between most of the medical staff and the chaplains and CPE students at the hospital where this project took place. I also knew there was an interest in the project, because I heard a lot of talk about the importance of meeting the emotional and spiritual needs of patients. There was certainly an appreciation for the value of responding compassionately to the religious and cultural needs of the patient. In practice, however, the medical staff was always seemed to be too busy. Some individuals did manage to keep the patient's spiritual needs in mind, but most of the time those needs remained quite low on the list of staff priorities. I had hoped that I could make a difference, and that spiritual care would come to take on a more significant role.

I now realize I was attempting to bring about a profound change of heart through fostering an intellectual adjustment. I should have known that education alone never changes the human heart. I neglected to realize the change of heart I wanted to foster had to be encouraged through a multi-faceted approach. The hospital staff could only be transformed through a similar kind of process that often works with my CPE students, namely, through having an opportunity to integrate what they were learning through reflecting upon what they had heard and testing it out in their actual work setting.

That was the first step in my transformation. The second one came while I was reflecting on those changes that *did* happen. I realized the medical staff had only begun to understand the true value of spiritual care when they themselves became the ones in need of spiritual care. It is our responsibility as professional spiritual caregivers to remain both sensitive and responsive to every opportunity to meet the spiritual needs of the medical staff, if we want them to value what we have to offer. This was a profound

realization for me. I now know any series of workshops or training modules, no matter how well designed or presented they might be, in and of themselves cannot catalyze such a radical change of heart. Such "education" only makes sense when it becomes an integral part of one's own life experience.

Student Transformation

My greatest joys as a CPE Supervisor occur when everything comes together for one or more of my students, and they experience a dramatic shift in their awareness. In these moments, the planning and execution of the curriculum, the ministry experiences of the student, the dynamics within the hospital, and the relationships within the Spiritual Care Department all come together to facilitate personal transformation. I think of these extraordinary learning experiences as *kairos* moments – those times when everything comes together at precisely the right time … in God's time. I see this most often when students find themselves in a ministry setting where they truly encounter the soul of a patient. In those moments, everything they have been learning begins to make sense to them. Several students have commented that those moments when they actually touched the soul of another, felt like the moment of their ordination to pastoral ministry.

During this demonstration project, one of my CPE students commented that offering the *Soul of Healing* modules allowed her to use an aspect of her pastoral ministry in a way she had never done within the hospital. This student had an extensive teaching background that she had not used in any previous hospital ministry experience. Her face glowed as she talked about how much she enjoyed having something tangible to offer to the nursing staff.

Staff Transformation

The *Soul of Healing* modules did not bring about a transformation among staff as far as I was able to determine. For the most part, the staff evaluations indicated they liked our presentations and gained something of value from them. I feel as though the training sessions were like spiritual seeds we had scattered among the nursing staff. Perhaps some of those seeds did land on fertile soil … only time will tell if any germinate and grow to fruitfulness.

The only clear experience of spiritual transformation happened when a staff member died. In the midst of their shared sorrow, ten staff members sought out the chaplain and encountered someone who could meet them at the level of their soul. How can anyone quantify what took place within the hearts of those ten? I feel confident they valued the pastoral ministry they received and gained a new appreciation for the importance of spiritual care for the soul. I remember from my own experience when a member of the medical staff had a critically ill son: I sat with him and I prayed with him. For years following that experience, he continually updated me on his son's recovery, development, and achievements. This man's soul was so deeply touched by that single encounter that he has never forgotten it. I am now convinced such soul-care opportunities are those occasions that have the power to bring about authentic transformation within the hearts and souls of hospital staff.

Conclusions

Seeking to facilitate transformation in even one person is a daunting task. Thus it is overwhelming to consider what might be involved in helping to facilitate an entire cultural transformation. I do believe such a transformation can happen. Chapman offers

a blueprint for creating the Healing Hospital,[41] one that requires a sustained commitment to love one another and to continually seek out opportunities to serve from that humble place of God's love, that fountainhead which lies deep within our own soul.

[41] Chapman, 101-182.

CHAPTER XI: IMPLICATIONS FOR MINISTRY

Offering *The Soul of Healing* training modules to hospital staff proved an interesting and challenging task. I found many physicians, nurses, and other caregivers were quite interested in the project and wanted to see the finished product. There were a number of difficulties. As one whose life has been focused on the subjective arts of spiritual and emotional care, I found the exacting demands and precise rigor of scientific study to be withering. At different points during this demonstration project, I had to withdraw from its intensity and recover my soul. My empathy for the medical community's struggle has in order to balance science and faith increased.

Affirmation of Interest

During my research into spirituality and healthcare, I saw ample evidence that physicians, nurses, and some hospital administrators were well aware that healthcare can easily fail in its primary mission when it neglects the soul. "There is an ever-present risk that we will surrender completely to one or all of (these) forces – to the enchantment of technology, to the lure of business profits, and to the lazy thoughtlessness of bureaucracy."[42] Recognizing this danger, many in healthcare are seeking ways to recapture the care of the whole person. The importance of addressing the spiritual needs

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[42] Ibid, 38.

of patients is significant enough that the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) is emphasizing the importance of including spiritual and emotional care in the hospital setting.

> The literature review provides strong evidence that emotional and spiritual needs affect health outcomes and hospital financial outcomes, and the survey reveals a strong relationship between the degree to which staff addressed emotional/spiritual needs and overall patient satisfaction. Care for patients' emotional and spiritual needs can therefore be considered a component of overall health care quality.[43]

The impetus to address the soul in healthcare provides an opportunity for the Spiritual Care department to help the hospital become an outstanding center of healing. Though this task will not be an easy one, and threats to excellent integrated healthcare still abound, we do have significant allies in our quest to move the soul of healing into the twenty-first century.

Challenges in the Setting

The current healthcare environment is in a state of continual challenge and discontinuous change. There exists intense pressure to acquire the latest technology, the most cost effective practices, and the most popular offerings. In the midst of these pressures, the state where this project took place has one of the nation's lowest ratios of nurses and physicians per thousand patients. The medical center, like the other hospitals in the state, is functioning with a significant shortage of professional medical staff. This strained environment is not conducive to spending time with patients or caring for their souls. Unfortunately, the qualities that are most conducive to an effective healing

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[43] Clark, 663.

environment (natural beauty, calm, quiet, a relaxed pace) are largely absent from this medical center and almost all other contemporary hospitals.

Although there was plenty of interest in this demonstration project, it proved quite difficult for those interested to find the time for serious education regarding spiritual care and cultural diversity. There are currently many demands upon our caregivers. There are always new regulatory and accreditation issues demanding attention. There are so many new technologies to learn and new and improved ways to fulfill the daily tasks of patient care. The nature of patient care is itself becoming increasingly complex and pressure continues to mount for hospital stays to get even shorter. The pace of healthcare has become so frantic that the cry of the soul has been all but lost in the din of "progress." When caregivers do make the time to learn about the spiritual aspects of healing, this new information can easily be forgotten in the face of the next major crisis. This may account for the fact that the *Soul of Healing* modules did not seem to have much of an impact on the number of referrals to or requests for consultations with the Spiritual Care Department.

The Chaplain's Role

This demonstration project brought home the need for chaplains to remain vigilant in keeping hospital staff aware of spiritual concerns. I believe teaching opportunities such as the *Soul of Healing* modules represent a good beginning, but they may not be sufficient to bring the souls of patients into the general consciousness of the hospital staff. The Spiritual Care Department of this hospital participates in several educational fairs throughout the year to highlight the many ways that we are an integral part of the healthcare team; and we also emphasize our services during Pastoral Care

Week and Hospital Week. The Spiritual Care Department has also sponsored a variety of educational programs over the years addressing those issues that arise whenever health and faith interact.

Education alone, however, will not be sufficient to bring about the necessary culture changes that will keep the whole patient within the heart of hospital care. Chaplains can reinforce the importance of their role by consistently bringing the patient's spiritual and emotional needs to the attention of those who are caring for patients, and by letting them know those ways in which they have helped patients and families cope with hospitalization. While documentation in the patient's medical chart is important, direct conversation with hospital staff provides an essential ingredient in promoting an integral healing environment.

As chaplains engage other healthcare professionals in interdisciplinary conversations and participate in bringing the soul of the patient into the plan of care, they become more visible to staff on the patient care units. When members of the hospital staff suffer illnesses, accidents, deaths in the family, or other catastrophes, the chaplains can take a more active role in assisting them with their own emotional and spiritual needs. I believe this is the ultimate place where learning the importance of the soul in healing truly happens. The most effective and enduring way to influence the culture of the hospital is for chaplains to address the soul needs of members of the hospital staff wherever and whenever they can. In my demonstration project, one student had ten staff members request personal support in the final week of the project. Those requests came because a member of the team on that unit had died. It was at that point that the importance of spiritual care became a reality for them.

Model for a New Kind of Hospital

Some hospitals in the United States are committed to becoming places where the souls of patients are both important and respected. These hospitals are willing to take radical steps to transform the entire organization and become centers for integral healing.

> All hospitals have a responsibility to place love at the center. Hospitals grounded in the Judeo-Christian tradition, in particular, are the last, best hope to restore loving care to the place Jesus intended it to be. In faith-based hospitals, we understand that we are all children of God and, therefore, we are all brothers and sisters. The Healing Hospital is grounded in these notions and offers a template for how to carry forward this sacred work in a series of Sacred Encounters.[44]

Because there are some hospitals which have already successfully integrated the spiritual and emotional needs of patients into the fabric of their institutions we have evidence that it can be done, but it takes an ongoing, sustained effort. My demonstration project revealed an interest in living into the promise of integrated healthcare at this medical center. It is a daunting task, but Chapman offers these steps to becoming a Healing Hospital: personal commitment, the practice of passion, the exploration of potential, the practice of presence, the practice of positive attitude, persistence, and the practice of prayer and meditation.[45]

As the voice of the soul within the current healthcare setting, chaplains have an essential role in shaping the Healing Hospital. If we care for our own souls and actively participate in the healing process of our patients and staff, we can be the change that we want to see in our hospitals and go about reclaiming the soul of healing.

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[44] Chapman, 110.

[45] Ibid, 144–6.

CHAPTER XII: SOUL OF HEALING TEACHING MODULES

In preparation for teaching the three *Soul of Healing* modules, I gave the students a week-by-week guide to assist them in planning for their teaching sessions and to help them avoid problems in teaching the modules. Here are the guidelines I provided:

Week 1:

- Talk with Nursing Director and Nurse Educator on your chosen unit (usually one or two pods) to schedule three fifteen-minute presentations or one hour-long presentation addressing the spiritual needs of patients, religious diversity, and cultural awareness. Work within the existing structures of the unit.
- Schedule room and time for presentations and learn how staff members are informed about such educational opportunities. Make sure that you will be scheduled to work and not be on call at the times you are to make the presentations
- Schedule the laptop and the projector for your designated presentation times
- Fill out your Student Survey for the week Weeks 2 – 6:

Preparing for the sessions:

- Copy several advertising flyers and post them on the unit
- Make copies of PowerPoint handouts and course evaluations for staff
- Copy PowerPoint notes pages for presentation script

- Invite staff as you see them – emphasize the short time commitment for each presentation. Remember to invite physicians and residents as well as nurses
- Check all equipment before taking it onto the floor Teaching Sessions:
- Presentation check list: laptop, power and connector cords, projector, PowerPoint CD, PowerPoint hand outs, staff evaluation forms, cookies for staff, PowerPoint notes pages
- While viewing module, allow ample time for staff questions
- Ask staff to complete the course evaluation
- Fill out your student survey for the week

Students arranged to make their presentations on a patient care unit where the nursing director was able to allow for the time and space for each session. Most of the sessions were offered in the staff lounge or conference area on the unit. Once the unit was determined and the time and place secured, the student began to advertise the sessions by posting flyers and personally inviting staff members.

An hour before each presentation, the student collected everything needed and took it to the designated place. When everything was ready, the student reminded people about the presentation.

The teaching module began with introductions of those whom the student did not know. Participants were given the handouts. During the PowerPoint presentation, participants had the opportunity to ask questions and respond to the information.

At the end of the session, participants were asked to complete a short evaluation to provide feedback regarding the usefulness of the teaching. These evaluations were

anonymous, so the staff could feel free to give their honest opinions. The survey questions were:

1. Which presentation are you evaluating?
    a. Encountering the Soul
    b. Awareness of Spiritual Diversity
    c. Awareness of Cultural Diversity
2. Please relate one new thing you learned from this presentation.
3. How comfortable are you in your ability to apply what you have learned from this presentation?

1 – Very Uncomfortable, 2 - Somewhat Uncomfortable, 3 - Neutral, 4 - Somewhat Comfortable, 5 – Very Comfortable

4. Please relate one thing that would have improved this presentation.

At the end of each session, the student was available to talk with the participants and answer questions, address concerns, or provide clarification regarding the presentation or specific patient concerns that the teaching module may have brought to mind.

APPENDIX A

PLAN OF IMPLEMENTATION AND COMPLETION OF PLAN

Plan of Implementation

Goal 1: To increase the awareness of CPE students regarding sensitivity to the needs of the patient, recognizing spiritual and religious diversity, and developing cultural sensitivity

Strategy 1: I will schedule presentations to the resident group about active listening, faith development, and at least two cultural groups

Objective 1: By the end of the Fall 2007 unit, students will have received five relevant presentations

Strategy 2: I will assign reading to facilitate student awareness of the specific needs of patients and to reinforce the presentations

Objective 2: By the end of the Fall 2007 unit, students will demonstrate reading of assigned texts by turning in summaries of assigned chapters

Strategy 3: I will train all residents in spiritual assessment skills

Objective 3: By end of the fall 2007 unit, all students will have accurate spiritual assessments 90% of the time.

Strategy 4: I will make use of verbatim seminars to reinforce student sensitivity and awareness of diversity issues in their ministry with patients

Objective 4: Students will present six verbatim reports before the end of the Fall 2007 unit. Each of these verbatim reports will be reviewed in verbatim seminar sessions with their peers and supervisor before the end of the Fall 2007 unit.

Goal 2: Equip students with the necessary tools to be able to teach about spiritual and religious diversity and cultural sensitivity to nursing staff on designated patient care units

Strategy 1: I will develop teaching modules for students to use with hospital staff

Objective *1: Modules will be developed in October 2007*

Strategy 2: I will review teaching modules with students

Objective 2: Modules will be reviewed and discussed with students before November 2007

Strategy 3: I will develop an information packet. This packet will have information to guide students through the process of setting up sessions, advertising sessions, and teaching the modules.

Objective 3: Students will have informational packets by the start of the teaching portion of the project.

Goal 3: Improve the students' pastoral role and professional relationships as members of a multidisciplinary team

Strategy 1: Students will use training sessions to educate staff about the importance of religious and cultural diversity awareness in patient care

Objective 1 Students will document offering three training sessions by the end of the Fall 2007 unit

Strategy 2: Following the training sessions, staff on the designated unit will have a clear understanding of the role of Spiritual Care.

Objective 2: The number of staff referrals to Spiritual Care will increase by 15% and the number of interdisciplinary consultations between students and hospital staff will increase by 20% on the designated patient care units

Response to Plan of Implementation

Goal 1: To increase the awareness of CPE students regarding sensitivity to the needs of the patient, recognizing spiritual and religious diversity, and developing cultural sensitivity

Strategy 1: I will schedule presentations to the resident group about active listening, faith development, and at least two cultural groups

Objective 1: By the end of the Fall 2007 unit, students will have received four relevant presentations

The following didactics relevant to the demonstration project were scheduled and presented during orientation and the Fall 2007 unit:

- Spiritual Assessment
- Pastoral Roles and Functions
- Getting to the Heart of a Visit (active listening, facilitating communication)
- Communication Skills
- Faith Development
- Ministry to Hispanic Patients
- Ministry to Native American Patients
- Nonviolent Communication
- Grief Recovery

- Immigration Issues

Strategy 2: I will assign reading to facilitate student awareness of the specific needs of patients and to reinforce the presentations

Objective 2: By the end of the Fall 2007 unit, students will demonstrate reading of assigned texts by turning in summaries of assigned chapters

I selected the following texts for student reading, with specific chapters assigned on a weekly basis. Additionally, I scheduled weekly sessions for the discussion of assigned chapters.

- Assigned reading for the unit – Gift to Listen, Courage to Hear by Cari Jackson; Biblical Themes for Pastoral Care by William Oglesby; or Basic Types of Pastoral Care and Counseling: Resources for the Ministry of Healing and Growth by Howard Clinebell (alternative text)
- All students submitted weekly summaries of their assigned readings and participated in group discussion regarding the assigned readings with attention to the application of the readings to their practice of ministry. Students reading the alternative text had previously read the Oglesby text.

Strategy 3: I will train all residents in spiritual assessment skills

Objective 3: By end of the fall 2007 unit, all students will have accurate spiritual assessments 90% of the time

The orientation to the hospital included training in the computer system for spiritual assessments. Three students in the residency program were familiar with the training and did not need to repeat it.

- I scheduled a training session at the beginning of orientation to train the new students in the use of the computer program (where the spiritual assessment was located).
- I led a discussion about how to make appropriate spiritual assessments.
- I worked with the new students individually as they wrote their first assessments.
- I reviewed the spiritual assessment protocol with the experienced students to ensure their accurate use of the spiritual assessment tool.
- The experienced students helped the two new students gain familiarity with the spiritual assessment tool.

In order to comply with regulatory requirements, I initially reviewed and co-signed student spiritual assessments. By the end of six weeks, all students were accurate in their spiritual assessments 90% of the time. Later, I developed an evaluation tool to document student accuracy with spiritual assessment. All students were able to achieve 100% on the evaluation tool and were able to move into the electronic chart without the need for my co-signature

Strategy 4: I will make use of verbatim seminars to reinforce student sensitivity and awareness of diversity issues in their ministry with patients

Objective 4: Students will present six verbatim reports before the end of the Fall 2007 unit. Each of these verbatim reports will be reviewed in verbatim seminar sessions with their peers and supervisor before the end of the Fall 2007 unit.

I developed a schedule for the unit, and each student presented six times.

- Students assessed themselves for their ability to listen to patients and to provide appropriate spiritual care

- Verbatim reports were discussed in the peer group to examine the students' strengths and areas for growth with attention to active listening, sensitivity to patient spiritual needs, and their religious and cultural needs

Goal 2: Equip students with the necessary tools to teach about spiritual and religious diversity and cultural sensitivity to nursing staff on designated patient care units

Strategy 1: I will develop teaching modules for students to use with hospital staff

Objective 1: Modules will be developed in October 2007

I developed the basic structure of the teaching modules in September and October 2007 and put them into PowerPoint.

Strategy 2 I will review teaching modules with students

Objective 2 Modules will be reviewed and discussed with students before November 2007

Students reviewed the three teaching modules during class time on October 26, October 31, and November 2. They discussed and evaluated the content with me. In response to these discussions, I adjusted each teaching module and developed a script to accompany each slide.

Strategy 3: I will develop an information packet. This packet will have information to guide students through the process of setting up sessions, advertising sessions, and teaching the modules.

Objective 3: Students will have informational packets by the start of the teaching portion of the project

Student packets were given to the students on November 2, 2007. Following the review of the teaching modules and after the scripting was completed, I created a CD for each student. The CD and some printed materiel were packaged in a folder. Students were asked to keep their evaluation forms in the folder and return the folder with the weekly self-assessment forms and staff evaluation forms at the end of the project. This was to insure that students could remain unidentified with a particular workshop evaluation and so that I could determine the changes in weekly assessments for the same student throughout the life of the project. Each folder had the following contents:

- A step-by-step guide regarding how to set up the teaching sessions on their assigned floors (hard copy and CD)
- A copy of the three separate teaching modules PowerPoint presentations (CD only)
- A copy of the three sessions assembled into one single presentation (CD only)
- A copy of the PowerPoint with script of the first session (Hard copy and CD; subsequent, CD only)
- A copy of the first session slides with accompanying notes pages for handouts (Hard copy and CD; subsequent, CD only)
- A copy of the student assessment that students were asked to complete on a weekly basis (hard copy and CD)
- A copy of the evaluation form for students to give to staff at the presentations (hard copy and CD)
- A copy of the three flyers to be used in advertising the teaching sessions (hard copy and CD)

Goal 3: Improve the students' pastoral role and professional relationships as members of a multidisciplinary team

Strategy 1: Students will use training sessions to educate staff about the importance of religious and cultural diversity awareness in patient care

Objective 1: Students will document offering three training sessions by the end of the Fall 2007 unit

I was unable to meet this objective as stated. Since most students were not able to follow the initial protocol, I made adjustments in the protocol and encouraged them to be flexible in order to accommodate their needs and the needs of the staff they were hoping to train. Overall, four students were able to teach at least some of the training modules and 36 staff members were able to attend at least part of the training.

- One student was unable to schedule any sessions on her assigned floors
- One student was able to schedule and teach all three sessions
- One student was able to schedule and teach one lengthy session where all three sessions were presented
- One student was able to schedule and teach two sessions, one for a single session and another with the remaining two sessions
- One student was only able to schedule and teach one single session
- Three of the five students were able to teach each segment of the training sessions in some form

Strategy 2: Following the training sessions, staff on the designated unit will have a clear understanding of the role of Spiritual Care

Objective 2: The number of referrals from staff to spiritual care will increase by 15%, and the number of interdisciplinary consultations between students and hospital staff will increase by 20% on the designated patient care units

I was unable to meet this objective. Students recorded on their weekly assessment forms the number of staff referrals and consults for the unit where they provided the training. The data did not demonstrate any consistent improvement in the number of referrals from staff to chaplains.

- One student documented an increase in referrals from 0 to an average of 3.5 in the final weeks of the project
- Other students showed no trend in referrals or showed a decline in the number of referrals
- One student had no referrals during the project
- Only the student who did not do the training had significant interdisciplinary consultations (Perhaps this was due to the nature of the particular student units, which were ICUs) *Note: This student told me that she was unable to schedule the presentations with her staff, for this reason, I knew who she was*
- One student had two consultations during the project. One came on the third week and the other on the fourth week
- No other students had interdisciplinary consultations on their designated units during the project

APPENDIX B

MINISTERIAL COMPETENCIES

My site team assisted me in this demonstration project by asking me to work on a variety of competencies. Out of the thirteen specific areas for proficiency, there were three general areas for me to address: analysis, strategic planning, and evaluation.

First Area of Competency to Develop

Cultivate analytical abilities in order to assess the ethical, social, and educational needs of those who will be impacted by the demonstration project and to determine what is feasible and limit workload accordingly.

Goal 1: Assess the ethical, social, and educational needs of CPE students, physicians-in-training, and nursing staff

Strategy: Consult with members of the Medical Education faculty, nursing directors, and CPE colleagues to determine the ethical, social, and educational needs of those impacted by this project

Objective: Before implementing the project, I will meet with a four professionals from the recommended disciplines to determine its ethical, social, and educational impact.

Implementation of strategy: I successfully addressed the objective for this goal. I met with the Program Directors for the Family Practice and Ob/Gyn Residencies, one of the hospital research coordinators, the nursing director for the original pilot unit; and a colleague who is an ACPE Associate Supervisor. With each of these individuals I discussed the relevant issues regarding implementing the project. The research coordinator was concerned that all participants be anonymous. One of the program directors expressed concern that the educational milieu would not be conducive to physicians-in-training participating in the project. There was a recommendation from

another medical education program director that the course be put into a computerized self-taught course that physicians-in-training could take at their leisure. This suggestion, while a good one, was not possible for this project. There was a consensus that education on religious and cultural diversity was important and worth pursuing. The concern for anonymity and the difficulty involving physicians-in-training led, in part, to my redesigning this project.

Goal 2: Determine what is feasible for the project and adjust the workload accordingly

Strategy Monitor workload to insure the capacity to adequately perform required tasks and fulfill the demands of the demonstration project.

Objective I will complete this DMin project before February 1, 2008 and meet the target dates for department assignments, student evaluations, and curriculum implementation

Implementation of strategy: To meet this goal, I extended my DMin by one year (original graduation was May 2007), and requested a two-week extension on the completion of my dissertation. Additionally, I resigned my position with the medical center in January 2008 because I was not able to fulfill my responsibilities and still have the time to complete the writing of my dissertation. Although I had to make adjustments that I would have preferred to avoid, I fulfilled this goal.

Second Area of Competency to Develop

Translate analysis into specific strategies for the successful implementation of the project. Take into consideration the need for clear communication, appropriate teaching methods, skillful use of group dynamics, and need for follow through.

Goal 1: Develop strategies to provide clear communication, appropriate teaching methods, skillful use of group dynamics, and follow through to successfully implement project

Strategy 1: Determine which individuals need to be informed about the project and determine the most effective means of communication with each individual in order to facilitate the timely completion of the project

Objective: During the life of the project, relevant individuals will be aware of what is happening with the project, any difficulties with the project, and adjustments to the project as they come up

Implementation of strategy: I did not fully meet this objective. I let most of the important individuals know what was happening at the beginning, but as I encountered seemingly insurmountable difficulties and almost gave up on the project, I did not let significant people know what was going on. I talked with my husband but did not inform my site team or my advisor. I did consult with my advisor, mentor, and the research coordinator about changing the focus of the project. I discussed progress on the project with my department director during our monthly meetings, and the CPE students were included in the planning stage as the project was finally coming together.

Strategy 2: Through the CPE group process, I will model the use of group as a means to teach students how to assess their own and each other's ministry skills. I will specifically focus on the skills of active listening, non-judgmental presence, and appropriate use of ritual.

Objective 2: By the end of the Fall 2007 unit, all CPE students in the resident group will be able to make use of the group process to demonstrate and discuss their own and others' ministry skills, including active listening, non-judgmental presence, and appropriate use of ritual.

Implementation of strategy: I successfully met this objective. Each student presented six verbatim reports to the group. Through my supervision of the group, they learned to assess their own strengths and weaknesses in their ministry with patients, specifically concerning active listening, non-judgmental presence, and appropriate use of ritual. Members of the group learned to give each other honest critique and became able to trust the critique of others.

Strategy 3: I will develop a plan and a target date for each stage of the demonstration project. If I am unable to meet the target date, I will adjust accordingly so that I can bring this demonstration project to completion.

Objective 3: By February 1, 2008 this demonstration project will be complete and I will have submitted it to the seminary for review.

Implementation of strategy: With several adjustments to my timeline, I was able to meet this objective. As mentioned above, I initially requested an extension of the project by one year to accommodate my work schedule. At several points during the project, I had to make adjustments due to difficulties within the hospital environment. I delayed the implementation of the project three times before I was finally able to implement it. I requested a two-week extension to enable me to complete the writing of the dissertation.

Third Area of Competency to Develop

I will cultivate evaluative skills to determine the success or failure of specific strategies and adjust the project in response to these evaluations.

Goal 1: To make adjustments in the demonstration project as needed in response to my evaluation of the success or failure of specific strategies

Strategy 1: I will notice whether my strategies are moving the project toward completion. Whenever I find that a plan is not working, I will adjust my plan so that the project will move to its conclusion

Objective 1: This demonstration project will be completed by February 1, 2008 and will reflect any necessary adjustments.

Implementation of strategy: During this demonstration project I had to make several significant adjustments. I first had to let go of my plan to complete the project in order to graduate in 2007. Then I had to change my original plan to use Press Ganey scores to assess the impact of improved education regarding our patients' spiritual and cultural needs. The hospital stopped using Press Ganey as an evaluation tool for patient satisfaction; and the new tool, NCR Picker, did not have a correlative for spiritual care. Another major change was to let go of my hope to include physicians-in-training in the project. The requirement for anonymity meant that I could not determine if training made any impact on the referring patterns of residents who had taken the training. Through my discussions with Medical Education faculty, it became clear that physicians-in-training would not have a priority for attending these training sessions. I also needed to redesign the project to focus more on the CPE student education process and on their interdisciplinary relationships with staff on their patient care units. The original project was to take place on one patient care unit to control for patient response and to note the

increase of referrals/consultations. In the new design, the students worked with the leadership on their units to find one unit where they could work with staff in the students' own areas. This reflected the new focus of this training: the student's role on the interdisciplinary team. Finally, I had to adjust the content of the training sessions. I presented four variations until I found content that resonated with the students and that was close to the time frame I intended for each session. I originally intended for there to be three sessions of ten minutes each. The final version included three twelve to fifteen minute sessions. I also adjusted the length of the project to reflect the simplicity of the new design. Because less data would be needed, this project ran for six weeks rather than the original ten weeks.

APPENDIX C

ORIENTATION AND FALL UNIT SCHEDULE

Orientation Schedule: Fall 2007

August 27		New Employee Orientation
August 28		New Employee Orientation
August 29	9:00 AM	Cerner/IPROB Training – Kelli Shepard, MDiv
	1:00 PM	Trauma Orientation and NINP – Angie Padilla-Jones, RN and Kelli
	2:00 PM	Shadow Residents/Staff
August 30	8:30 AM	Office Procedures – Ramona Yoder
	10:00 AM	Policies/Procedures – Carol McAninch-Pritz, MDiv
	12:30 PM	ED Orientation – Becky Shocklee
	2:00 PM	Shadow Residents/Staff
August 31	8:30 AM	Statistics, Logs, Medicare Passthru - Carol
	10:30 AM	WT6 (Behavioral Health) Orientation – Phyllis Patton
	11:15 AM	L&D Orientation – Mary Kempton, RN
	1:00 PM	Rehab Orientation - Phyllis
	2:00 PM	Shadow Residents/Staff
	5:00 PM	Welcome Party – Carol's House
September 3		Holiday
September 4	8:30 AM	Spiritual Assessment – Carol
	10:00 AM	Interpreter Program – Maria Burruel
	11:00 AM	Bone Marrow Transplant Orientation – Julie Overbey, RN
September 5	9:00 AM	Disaster Protocol – Mary Alice Witzel, RN
	10:00 AM	Patient Relations – Advanced Directives – Kaaren DeShay
September 6	9:00 AM	Risk Management – Doris McVey, RN
	10:00 AM	Medical Terminology – Bryan Glick, DO
September 7	9:00 AM	Library Orientation – Lora Robbins
	9:30 AM	Computer Lab – Frank Wallace
	10:00 AM	Computer Mandatories
	2:00 PM	Commissioning Service – Sandstone North
September 10	9:00 AM	Case Mgt/Social Work – Caroline Green, MSW

September 11	9:00 AM	Service Excellence – Susan Ritter
September 12	9:00 AM	Orient. to Nursing – Coleen Halberg, RN, CNO
September 13	9:00 AM	Donor Network – Gail Farrell
September 14	9:00 AM 9:30 AM	Hospital Administration – Larry Volkmar, CEO Administration and Chaplaincy - Joan Theil, RN, Associate Administrator
September 17	9:00 AM	Morgue Procedures – Jerry Fillemon
September 18	9:00 AM 11:00 AM	Families Presence at Codes – Gayle Marble, RN Ministry in the ICU – Sue Hurst, RN
September 19	9:00 AM	PR – High Profile Cases – Jennifer Pool
September 20	8:30 AM	Tea for the Soul – Silvia Tiznado, MDiv
September 21	9:00 AM 1:00 PM	Conflict Resolution – George Joumas Communication Skills – Heather Ferguson
September 24	9:00 AM	Grief Recovery – Cindy Darby, MDiv
September 27	9:00 AM 10:00 AM	Family/Physician Conferences – Kelli Immigration Issues - Silvia
September 28	9:00 AM	Transfusion Services – Richard Melseth

Fall Unit Schedule

October 1	8:30 AM	Review Course Requirements - Carol
	10:30 AM	Personal Narrative - Spiritual Journey
October 3	8:30 AM	Cont. Course Requirements - Carol
	10:30 AM	Introduce DMin Project – Carol
October 5	8:30 AM	Learning Goals
	10:30 AM	Intro to Critical Incident Stress Management – Heather Ferguson
October 8	8:30 AM	Verbatim 1
	9:30 AM	Verbatim 2
	10:45 AM	Group Covenant
October 10	8:30 AM	Verbatim 3
	9:30 AM	Meyers-Briggs – George Joumas
	11:00 AM	Reading Review – Jackson, Section 1 Clinebell – Chapter 1
October 12	8:30 AM	Verbatim 4
	9:30 AM	Verbatim 5
	10:45 AM	Personal Narrative – Heroes
October 15	8:30 AM	Verbatim 6
	9:30 AM	Getting to the Heart of the Visit – Carol
	10:45 AM	Interpersonal Relationship Seminar
October 17	8:30 AM	Verbatim 1
	9:30 AM	Reading Review Jackson, Section 2 Clinebell, Chapter 2
	10:30 AM	Overview of Mood and Thought Disorders Jay Swartz, MSW
October 19	8:30 AM	Verbatim 2
	9:30 AM	Verbatim 3
	10:45 AM	Faith Development - Carol
October 22	8:30AM	Verbatim 4
	9:30 AM	Verbatim 5
	10:45 AM	IPR
October 24	8:30 AM	Depression Documentary and discussion
	10:30 AM	Personal Narrative – Crossroads
October 26	8:30 AM	Verbatim 6

	9:30 AM	Reading Review	Jackson, Section 3 Clinebell, Chapter 3
	10:45 AM	Review "Soul of Healing – Encountering the Soul"	
October 29	8:30 AM	Verbatim 1	
	9:30 AM	Verbatim 2	
	10:45 AM	IPR	
October 31	8:30 AM	Review "Soul of Healing – Awareness of Spiritual Diversity"	
	9:30 AM	Reading Review	Oglesby, Chapter 1, Clinebell, Chapter 4
	10:30 AM	Palliative Care – Mary Whitmer, RN	
November 2	8:30 AM	Review "Soul of Healing, Awareness of Religious and Cultural Diversity" and discuss DMin	
	10:00 AM	Verbatim 3	
	11:00 AM	Zudhi Jasser, MD, Overview, Bio-medical Ethics	
November 5	8:30 AM	Verbatim 4	
	9:30 AM	Verbatim 5	
	10:45 AM	IPR	
November 7	8:30 AM	Verbatim 6	
	9:30 AM	Reading Review	Oglesby, Chapter 2 Clinebell, Chapter 5
	10:30 AM	Pastoral Roles and Functions - Silvia	
November 9	8:30 AM	Mid-Unit Evaluations	
November 12	8:30 AM	Verbatim 1	
	9:30 AM	Verbatim 2	
	10:45 AM	IPR	
November 14	8:30 AM	Verbatim 3	
	9:30 AM	Verbatim 4	
	10:30 AM	Family Systems – Kelli	
November 16	8:30 AM	Verbatim 5	
	9:30 AM	Verbatim 6	
	10:45 AM	Reading Review	Oglesby, Chapter 3 Clinebell, Chapter 6
November 19	8:30 AM	Verbatim 7	
	9:30 AM	Self-Care – Carol	
	10:45 AM	IPR	
November 21	8:30 AM	Suicide Documentary	
	10:45 AM	Reading Review	Oglesby, Chapter 4 Clinebell, Chapter 7

November 23	No Class		
November 26	8:30 AM	Ministry with Native American patients Cathy Witte, Chaplain, Phoenix Indian Hospital	
	10:00 AM	Verbatim 1	
	11:00 AM	IPR	
November 28	8:30 AM	Verbatim 2	
	9:30 AM	Verbatim 3	
	10:45 AM	Reading Review	Oglesby, Chapter 5 Clinebell, Chapters 8-9
November 30	8:30 AM	Verbatim 4	
	9:30 AM	Verbatim 5	
	10:30 AM	"Wit"	
December 3	8:30 AM	Verbatim 6	
	9:30 AM	Verbatim 7	
	10:45 AM	IPR	
December 5	8:30 AM	Verbatim 1	
	9:30 AM	Verbatim 2	
	10:45 AM	Reading Review	Oglesby, Chapter 6 Clinebell, Chapters 10-11
December 7	8:30 AM	Verbatim 3	
	9:30 AM	Verbatim 4	
	10:30 AM	Ministry at Traumatic Death, Silvia	
December 10	8:30 AM	Verbatim 5	
	9:30 AM	Verbatim 6	
	10:45 AM	IPR	
December 12	8:30 AM	Verbatim 7	
	9:30 AM	Article Review	
	10:45 AM	Non-Violent Communication, Carol	
December 14	8:30 AM	"Tuesdays with Morrie"	
	10:45 AM	Personal Narratives - Transitions	
December 17	8:30 AM	Final Evaluation (Adjustment due to emergency)	
	10:00 AM	IPR	
December 19	8:30 AM	Final Evaluations	
December 21	8:30 AM	Final Evaluations	
	12:00 Noon	End of Unit Celebration	

APPENDIX D

OUTCOMES AND STUDENT RESPONSES

Data for Student 1

Did Not	complete presentation 1	Participants	0
Did Not	complete presentation 2	Participants	0
Did Not	complete presentation 3	Participants	0

Number of staff requests for patient to be seen during week

11/5	11/12	11/19	11/26	12/3	12/10
7	2	0	8	0	3

Number of staff seeking personal assistance during week

11/5	11/12	11/19	11/26	12/3	12/10
4	3	2	1	0	2

Number of interdisciplinary consults during week

11/5	11/12	11/19	11/26	12/3	12/10
9	4	2	4	2	8

Ranking scale

1-very uncomfortable 2-somewhat uncomfortable 3-neutral 4-somewhat comfortable 5-very comfortable

Level of comfort with staff

11/5	11/12	11/19	11/26	12/3	12/10
5	5	4	5	5	5

Staff awareness of the role of spiritual care

11/5	11/12	11/19	11/26	12/3	12/10
5	5	4	4	5	5

Comfort discussing patient spiritual needs with staff

11/5	11/12	11/19	11/26	12/3	12/10
5	5	4	4	5	5

Data for Student 2

Did Not	complete presentation 1	Participants 0
Did	complete presentation 2	Participants 7
Did Not	complete presentation 3	Participants 0

Number of staff requests for patient to be seen during week

11/5	11/12	11/19	11/26	12/3	12/10
2	2	8	0	3	1

Number of staff seeking personal assistance during week

11/5	11/12	11/19	11/26	12/3	12/10
2	2	1	1	0	10

Number of interdisciplinary consults during week

11/5	11/12	11/19	11/26	12/3	12/10
0	0	1	1	0	0

Ranking scale

1-very uncomfortable 2-somewhat uncomfortable 3-neutral 4-somewhat comfortable 5-very comfortable

Level of comfort with staff

11/5	11/12	11/19	11/26	12/3	12/10
4	4	5	5	5	5

Staff awareness of the role of spiritual care

11/5	11/12	11/19	11/26	12/3	12/10
4	4	4	4	4	4

Comfort discussing patient spiritual needs with staff

11/5	11/12	11/19	11/26	12/3	12/10
5	5	5	5	5	5

Data for Student 3

Did	complete presentation 1	Participants	2
Did	complete presentation 2	Participants	2
Did	complete presentation 3	Participants	4

Number of staff requests for patient to be seen during week

11/5	11/12	11/19	11/26	12/3	12/10
-	0	0	0	0	0

Number of staff seeking personal assistance during week

11/5	11/12	11/19	11/26	12/3	12/10
-	0	0	0	0	0

Number of interdisciplinary consults during week

11/5	11/12	11/19	11/26	12/3	12/10
-	0	0	0	0	0

Ranking scale

1-very uncomfortable 2-somewhat uncomfortable 3-neutral 4-somewhat comfortable 5-very comfortable

Level of comfort with staff

11/5	11/12	11/19	11/26	12/3	12/10
-	4	4	4	4	4

Staff awareness of the role of spiritual care

11/5	11/12	11/19	11/26	12/3	12/10
-	2	2	2	2	2

Comfort discussing patient spiritual needs with staff

11/5	11/12	11/19	11/26	12/3	12/10
-	5	5	4	4	4

Data for Student 4

Did	complete presentation 1	Participants	9*
Did	complete presentation 2	Participants	9*
Did	complete presentation 3	Participants	9*

Number of staff requests for patient to be seen during week

11/5	11/12	11/19	11/26	12/3	12/10
4	6	3	2	0	1

Number of staff seeking personal assistance during week

11/5	11/12	11/19	11/26	12/3	12/10
2	0	0	3	0	6

Number of interdisciplinary consults during week

11/5	11/12	11/19	11/26	12/3	12/10
0	0	0	0	0	0

Ranking scale

1-very uncomfortable 2-somewhat uncomfortable 3-neutral 4-somewhat comfortable 5-very comfortable

Level of comfort with staff

11/5	11/12	11/19	11/26	12/3	12/10
5	5	5	5	5	5

Staff awareness of the role of spiritual care

11/5	11/12	11/19	11/26	12/3	12/10
5	5	5	5	5	5

Comfort discussing patient spiritual needs with staff

11/5	11/12	11/19	11/26	12/3	12/10
5	5	5	5	5	5

- All three presentations were done together

Data for Student 5

Did	complete presentation 1	Participants	7
Did	complete presentation 2	Participants	5*
Did	complete presentation 3	Participants	5*

Number of staff requests for patient to be seen during week

11/5	11/12	11/19	11/26	12/3	12/10
0	1	3	4	4	3

Number of staff seeking personal assistance during week

11/5	11/12	11/19	11/26	12/3	12/10
0	0	0	0	0	0

Number of interdisciplinary consults during week

11/5	11/12	11/19	11/26	12/3	12/10
0	0	0	0	0	0

Ranking scale

1-very uncomfortable 2-somewhat uncomfortable 3-neutral 4-somewhat comfortable 5-very comfortable

Level of comfort with staff

11/5	11/12	11/19	11/26	12/3	12/10
4	4	4	4	4	4

Staff awareness of the role of spiritual care

11/5	11/12	11/19	11/26	12/3	12/10
3	3	3	4	4	4

Comfort discussing patient spiritual needs with staff

11/5	11/12	11/19	11/26	12/3	12/10
4	4	4	4	5	5

- Presented together

Table Demonstrating Student Responses

Student/Staff Contacts (Actual Numbers)

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
Referrals	13	11	14	14	7	8
Staff Shares Personal Needs	8	5	3	5	0	18
Interdisciplinary Conferences	9	4	3	5	2	8

Student Level of Comfort (Scale of 1-5)

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
Student Comfort with Staff	4.5	4.4	4.4	4.6	4.6	4.6
Staff Aware of Chaplain Role	4.25	3.8	3.6	3.8	4	4
Student Comfort with Role	4.8	4.8	4.4	4.4	4.8	4.8

APPENDIX E

RESPONSES FROM STAFF EVALUATIONS

Number of staff attending session 1, “Encountering the Soul” – 18

Number of staff attending session 2, “Awareness of Spiritual Diversity” – 23

Number of staff attending session 3, “Awareness of Religious and Cultural Diversity” -18

Number of staff indicating comfort with applying what they learned in their work

Very Uncomfortable	2
Somewhat Uncomfortable	3
Neutral	7
Somewhat Comfortable	16
Very Comfortable	8

The numbers do not add up because some staff members attended a single presentation comprising more than one training session.

Responses to: “ Please relate one new thing you learned from this presentation”:

- There were several responses regarding the importance of sitting or spending time with the patient as a valuable addition to patient care. These responses were: “sitting with patient makes a difference to them,” “sitting with patient seems longer,” “take even a few minutes to sit and talk with patient,” “time with patient is very valuable,” “sitting down with patient is good,” “sitting is important when you talk with patients,” “sit at bedside,” and “pause before entering the room.”
- Several responses indicated a new awareness of different expressions of spirituality. These responses were: “spiritual diversity,” “spiritual mysticism and phenomena are new ways spirituality presents itself,” “breathing techniques as part of spirituality,” “spirituality can be as simple as visualizing nature,” “reminder nature can be spiritual,” “mystical events as a spiritual encounter,”

"some patients don't have a religious preference but may still want a visit or prayer."

- Some responses indicated a new awareness of the scope of diversity. These responses were: "focusing on cultural diversity," "we have a very different population in Arizona that the world," and "you can't make others see it your way."
- Other responses indicated a new awareness of attending to the spiritual, cultural, and religious diversity of patients. These responses were: "soul plays a part in healing," "presence of chaplain (is important) at times of increased stress in patient's life," "we have a language and cultural services department."
- One comment was unclear if the staff member learned about themselves or about others. They simply responded, "religious biases."

Responses to: "Please relate one thing that would have improved this presentation":

- There were four suggestions regarding the milieu: "better room", "seating arrangement", "harder to concentrate during business hours", and "more nurse participation."
- Two participants wanted more detailed, specific information: "informative email of capabilities of spiritual care department, resources, point people, and availability," and "show graphic of Arizona population culturally."
- One participant wanted more visuals: "Pictures."
- Two suggestions were unclear: "focusing patient" and "more questions."
- Six comments specifically stated that they had no suggestions for improvement or reported that the sessions were good.

APPENDIX F

STUDENT HANDOUTS FOR PRESENTATION

Guidelines for Participation

Week of November 5

- Talk with Nursing Director and Nurse Educator on your chosen unit (usually one or two pods) to schedule three fifteen minute presentations or one-hour long presentation addressing the spiritual needs of patients, religious diversity, and cultural awareness. Work within the structures of the unit.
- Schedule room and time for presentations and learn how staff members are informed about such educational events. Make sure that you will be scheduled to work and not on call at the times you are to present
- Schedule laptop and projector for your designated presentation times
- Fill out your Student Survey for the week

Week of November 12

- Post flyers advertising the presentation
- Make copies of PowerPoint slides with room for notes
- Invite staff as you see them – emphasize the short time commitment for presentation. Remember to invite physicians and residents as well as nurses
- Offer segment of workshop
- Ask for feedback from staff about how helpful segment was
- Fill our Student Survey for the week

Week of November 19

- You will probably not schedule any presentations during this week
- Fill out Student Survey for the week

Weeks of November 26, December 3, and December 10

Same as week of November 12

Program will end on December 14 – Turn in Student Surveys to Carol McAninch-Pritz

Student Survey

Date_____

How many staff requests to visit patients did you receive on this unit during the past week?

How many staff members on this unit approached you with personal concerns in the past week?

How many interdisciplinary consults did you participate in on this unit during the past week?

Rate your level of comfort with the staff on this unit.

Very Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Very Comfortable
1	2	3	4	5

Rate the staff's level of awareness of the role of Spiritual Care on this unit.

Very Unaware	Somewhat Unaware	Neutral	Somewhat Aware	Very Aware
1	2	3	4	5

How comfortable are you discussing patient spiritual needs with staff?

Very Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Very Comfortable
1	2	3	4	5

Use the back of this form to comment or give feedback about this project and its impact on your work on this unit.

Feedback Form

1. Which presentation are you evaluating?
    a. Encountering the Soul
    b. Awareness of Spiritual Diversity
    c. Awareness of Cultural Diversity

2. Please relate one new thing you learned from this presentation.

3. How comfortable are you in your ability to apply what you have learned from this presentation?

Very Uncomfortable	Somewhat Uncomfortable	Neutral	Somewhat Comfortable	Very Comfortable
1	2	3	4	5

4. Please relate one thing that would have improved this presentation.

APPENDIX G

FLYER FOR PRESENTATIONS

The Soul of Healing:

Encountering the Soul

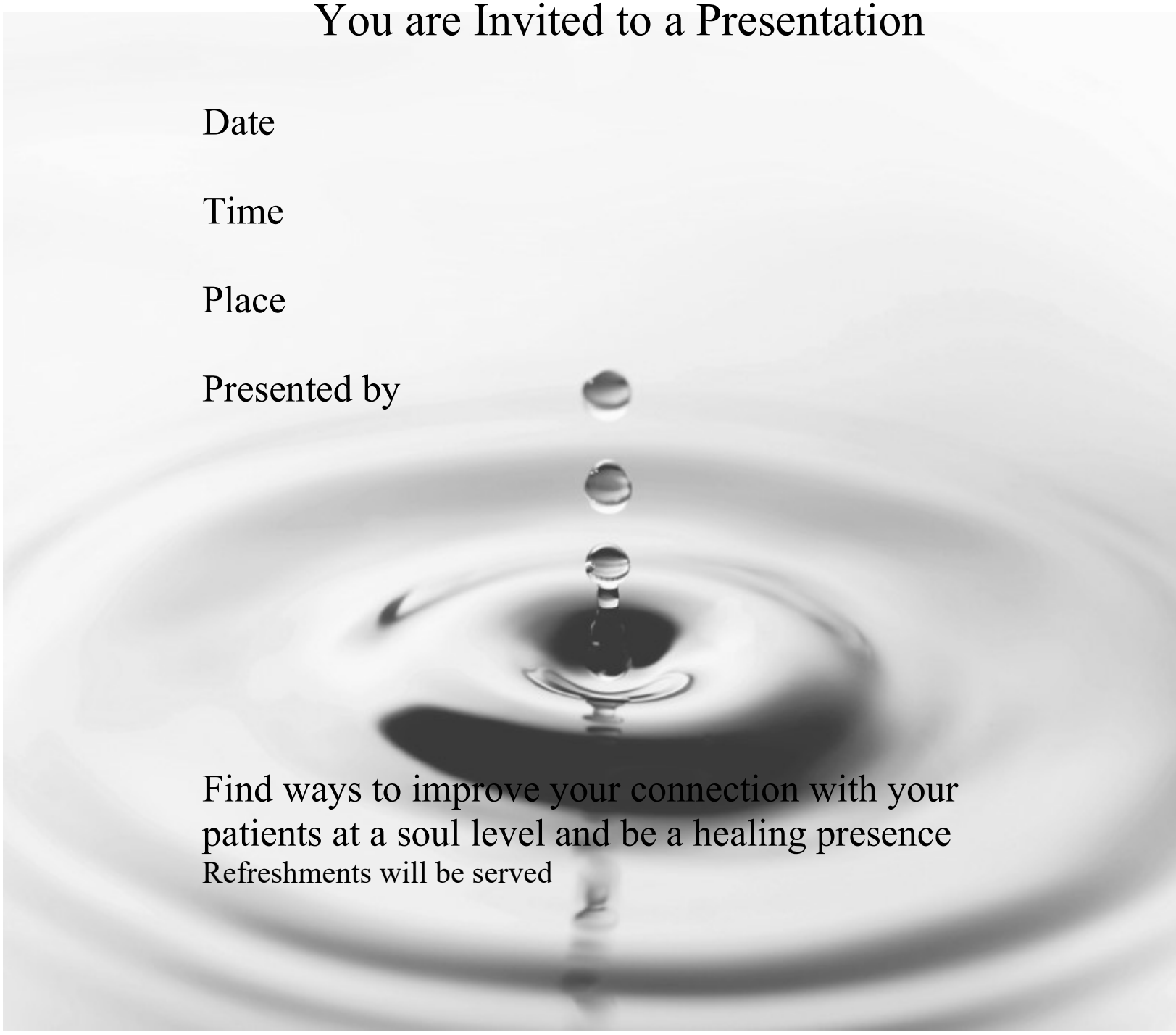
You are Invited to a Presentation

Date

Time

Place

Presented by



Find ways to improve your connection with your patients at a soul level and be a healing presence

Refreshments will be served

APPENDIX H

SOUL OF HEALING PRESENTATION

This is a sessions to increase awareness of the spiritual, religious and cultural needs of patients.

Encountering the Soul

Addressing the inner life of the patient

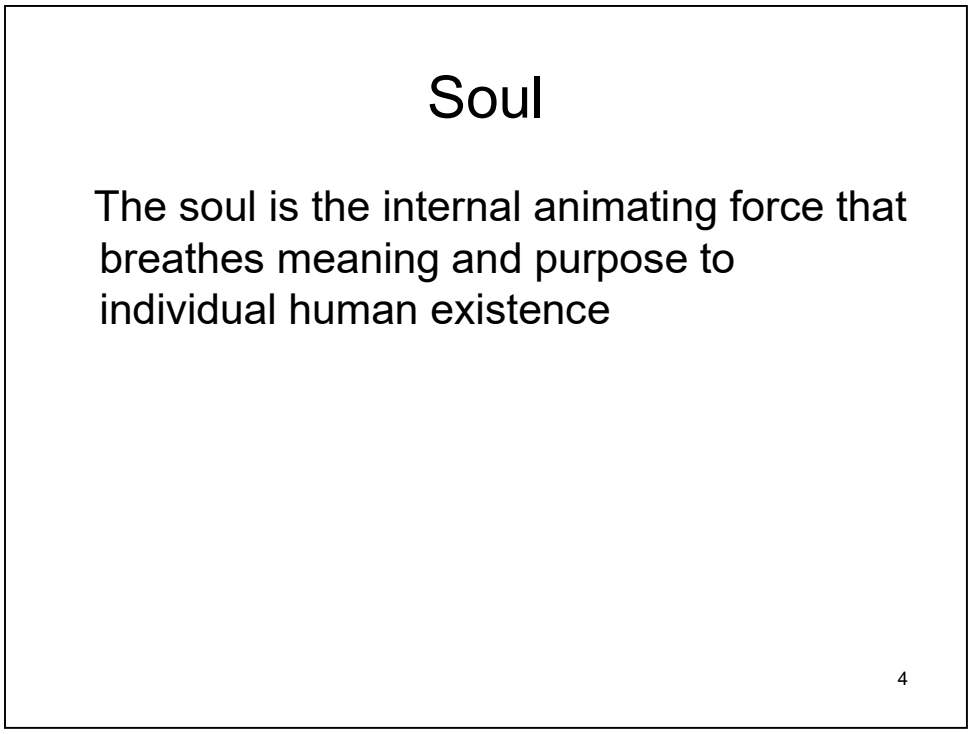
2

Objectives of part 1

- Identify and articulate the role of the soul in patient well-being
- Develop the skills to form a soul connection with the patient

3

By the end of this session, you will be able to state why it is important to address the inner dimension of the patients that you work with. This session will also help you identify simple actions that will make it more likely to engage the patients and their families at this level that we are calling “the soul”.



This definition of the Soul was used by the author of this session, Carol McAninch-Pritz to delimit the topic and to give a common ground for understanding. This is not an exhaustive definition. Are there any questions?

Role of the Soul in Patient Well-being

- Provides a context for making meaning out of illness or injury
- Offers a sense of stability when illness disrupts daily life
- Facilitates the incorporation of changes brought on by illness or injury

5

Many studies in recent years have demonstrated that the emotional and spiritual life of people has an effect on their physical health. The purpose of this session it to discuss the effects upon the inner life of the patient when the healthcare professional gives attention to this aspect of the patient. As the care team acknowledges the emotional and spiritual needs, the patient is able to access the strengths of their soul to bring hope and meaning into the situation. As patients and their families are able to garner their inner resources to cope with the affects of illness, there is increased likelihood that the impact of the soul will be positive rather than negative.

Advantages of meeting the soul needs of the patient

- Increased commitment to and compliance with treatment plan
- Potential for improved medical outcomes
- Reduced stress on patient and family
- Stronger relationships between patients and the medical team

6

It is important that patients understand the objective data about their disease process. However, it is also important that the patient be allowed to express their emotional responses to this information. When a care provider takes time to listen to the patient's subjective concerns, the patient is more likely to feel valued as a person. To hear the patients subjective concerns, understand that in addition to needing factual information, patients often need medical staff to hear that the emotional impact of the disease is a subjective experience that will likely not be addressed by objective data. Just hearing that the patient has fear or is feeling overwhelmed is often enough to relieve much of the anxiety the patient is feeling. Once the patient feels heard, the patient is far more likely to trust staff and cooperate with the treatment plan.

How to Make a Soul Connection with the Patient

- Focus on the present moment
- Take a few deep breaths
- Silently repeat the person's name as you prepare to enter their space
- Resolve to be compassionate

7

At first, it may seem that it would be too time consuming or cumbersome to add the patient's emotional and spiritual concerns to your care of a patient. There are, however, a few practices that can be incorporated into the routine care of the patient that will add no time to the intervention, but which will address many of the psycho, social, and spiritual concerns of the patient. Here is something you can try the next time you see a patient. While you are washing your hands, take a moment to focus on the present moment and take a few deep breaths. As you breathe, repeat the patient's name a couple of times and choose to meet the patient with compassion. See if this makes a difference in the way you see the patient and in the way the patient responds to you.

Making a Soul Connection with the Patient

- Observe the patient and their setting.
- Give the patient your full attention
- Make the patient feel more at ease by trying to sit while you talk
- Take cues from the patient regarding their level of comfort with eye contact and personal space

8

Once you are in the room with the patient, notice the ambient feeling of the room and pay attention to the patient's body language. Keep your mind focused on the patient and the present moment and keep your physical movements to a minimum. Try to sit as you talk with the patient if convenient. Sitting tells the patient, non-verbally, that you have time to listen. Patients perceive that their caregiver spends more time with them when they sit. Notice how patients react when you move close and give direct eye contact. Let their responses guide you in determining their need for personal space and their comfort with eye contact.

Making a Soul Connection with the Patient

- Notice the patient's emotional undercurrents
- Ask how illness is affecting daily life
- Listen for clues about coping styles or problems
- When giving the patient or family information, ask "What did you hear me say?" and clarify any misunderstandings

9

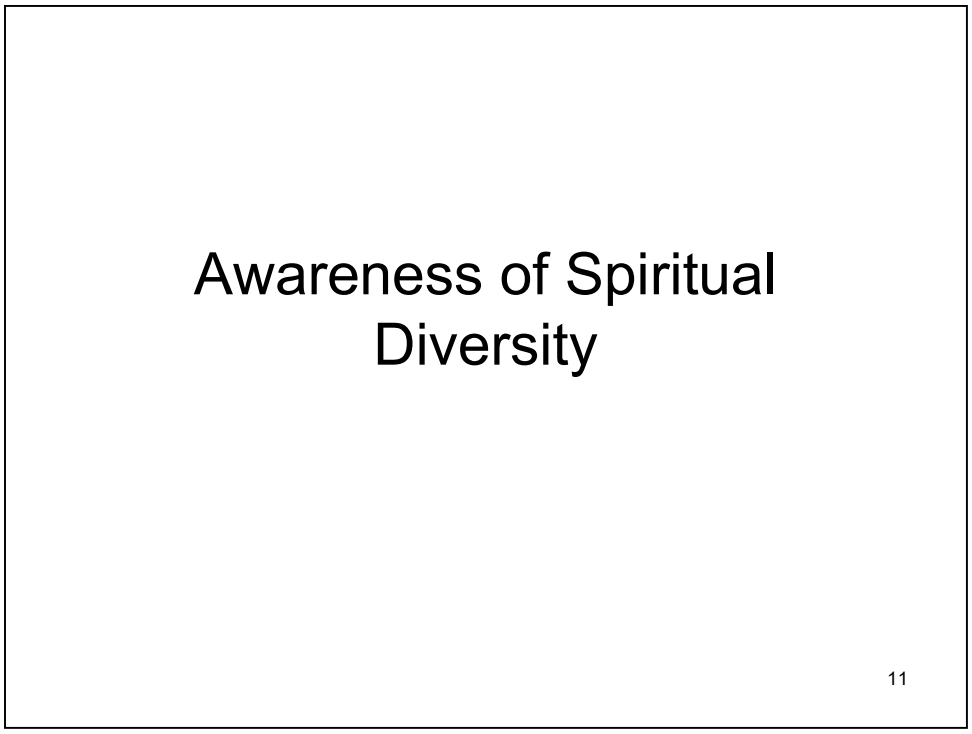
As you talk with your patients, watch and listen for emotional as well as physical reactions to their illnesses. If patients articulate an emotional response as well as a physical one, respond to the emotional and spiritual concerns as well as the physical ones. If the patient needs more time to address their soul concerns than you have, please contact the Spiritual Care Department for a consultation. Finally, rather than ask if a patient has understood, ask what they heard you say. It is a challenge for most patients to confess that they do not understand and most will just say that they understand. As patients tell you what they heard, you may find that they only heard part of what you said or that they misunderstood altogether. You can make sure that your information is clearly received in the moment rather than several days after a problem came up due to miscommunication. In all of these actions, use a respectful tone and treat the patient as you would treat a close loved one in their place.

The Soul of Healing

The more healthcare givers perceive the role of the soul in healing, the better they can understand the advantages of caring for the whole patient and take concrete steps to facilitate healing

10

Do you have any questions or discussion about what you have heard?



This is part two of our presentation dealing with the cultural and spiritual needs of patients. In this section we will look at a variety of spiritual and religious expressions that are common to many patients.

Objectives of Part 2

- Articulate the different expressions of spirituality that are common in patient populations
- Develop the ability to assist patients to make use of their spiritual life to assist in healing

12

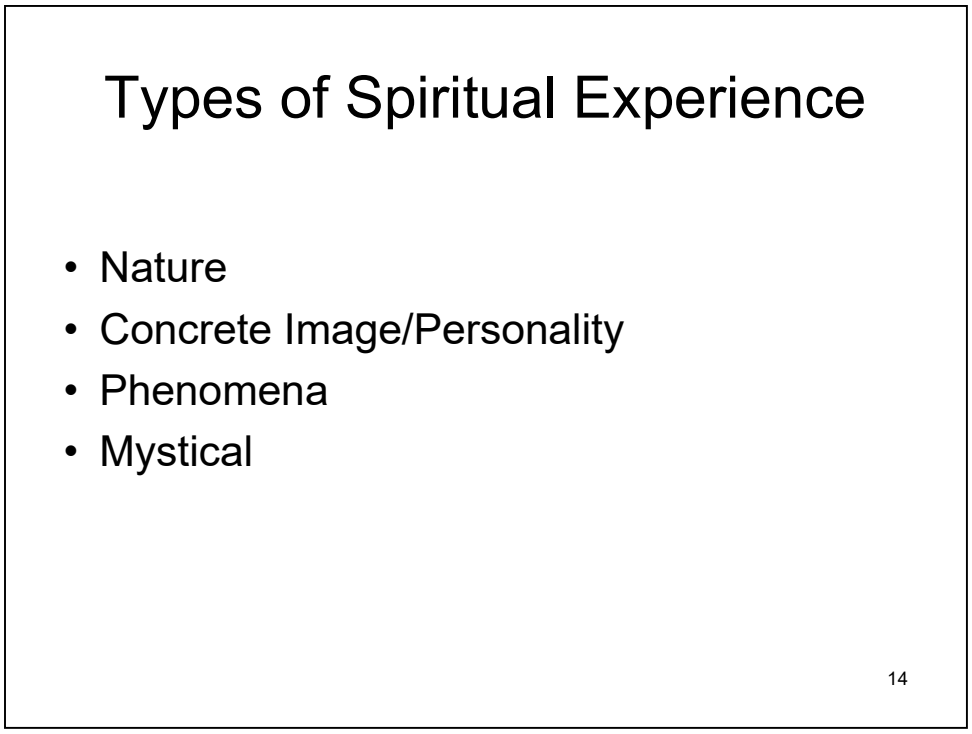
By the end of this session you will be able to articulate different expressions of spirituality. You will also be able to apply some simple actions to assist patient to make use of their spirituality to assist them in their healing process.

Spirituality

The subjective, transcendent experience through which one develops an internalized value system, locus of meaning, and sense of purpose for one's life. It is usually shaped by culture and/or religion but may move beyond them.

13

So that we understand each other, the definition of spirituality that we are using for this program is one that can be used with patients whether or not they are active in a religious community.



Individuals have many ways in which they can experience their spirituality. We will explore four different kinds of spiritual experiences. Anyone can have one or more of these types of experiences. Although people may have one type of spiritual experience that is most common and familiar for them, most people have a variety of ways that they experience the spiritual part of their life. Some religious practices cultivate specific experiences, however, these experiences can happen spontaneously, without any effort or expectation from the person who has them. The more one cultivates a spiritual practice, the more common spiritual experiences will be for that one.

Nature Spiritual Experience

This spiritual experience occurs when one finds a connection to the transcendent plane through nature. It does not require a belief in a “Higher Power” or God.

15

Many people have had a profound experience where they are moved beyond themselves while in nature. These experiences of awe can happen while walking in the mountains, watching the ocean, observing an eagle in flight. In a nature based spiritual experience, a person feels connected with all of life or creation.

Nature Spiritual Experience

- Use of Nature
  - View from window, walking outside, attending to plants
  - Video of nature scenes
  - Visualization
  - Recalling previous experiences

16

For those whose spirituality primarily comes through nature, one can assist the healing process by reconnecting them with nature. For those who are able, walking among plants and flowers may help a patient relax. When actual movement in nature is not possible, having plants or flowers nearby and helping the patient attend to the beauty and intricacy of the living plants can sometimes be helpful. At other times a patient may reconnect with their sense of spirituality by watching a video presentation that shows nature scenes with natural sounds. Also, a patient can sometimes recreate a spiritual connection by remembering in detail a previous nature spiritual experience that was especially powerful. As patients remember the previous experiences, they can recreate much of the same state of mind of the earlier encounter.

Concrete Images/Personality

In this state of spiritual awareness, one finds a connection to the divine through an experience with a higher spiritual being. This being may be in the person of Jesus Christ, the Ancestors, Shiva, or some other embodiment or manifestation of God.

17

Many people have had powerful spiritual experiences when they have encountered a concrete image or personal relationship with some aspect of the divine. For example, many Christians feel a strong connection with God through the person of Jesus Christ and feel an intimate relationship that is manifest in prayer. Others may feel connected with a particular saint or spirit guide, and others may feel connected with a relative who has died but with whom they can communicate through mental conversation or dreams. Still others may feel connected with an image that symbolizes the divine but does not have a human shape such as a cross, circle, or flame. Many individuals feel this type of spiritual experience through recalling the names or attributes of God: such as faithfulness, compassion, or grace. Most religions have some aspect of this spiritual experience and seek to transmit this depth of encounter through human language and symbols that help members of that faith community connect to God again and again through familiar paths.

Concrete Image/Personality Spiritual Experience

- Using Concrete Images/Divine Personality
  - Prayer to God
  - Scripture or sacred songs
  - Symbols
  - Actual image
  - Mental image

18

Patients are in the best position to tell you which images will assist them in activating a concrete connection with the divine. Specific scriptures or songs may describe an image that works for a person. A Jewish patient may use a scroll of the Torah or a Muslim may find the Koran as the symbol that facilitates the sacred encounter. For a Mexican Catholic, Our Lady of Guadalupe may facilitate a powerful spiritual experience. Often the image that speaks most powerfully to a patient are personal and may not be meaningful to someone outside of the family. Let patients assist you as they relate images that work for them.

Phenomena Spiritual Experience

This spiritual experience describes events that occur as a communication from the divine or a spiritual presence through a non-rational means.

19

Many people connect with the divine through experiences that have purpose and communicate in ways that can not be explained rationally. For example, a person may feel a strong premonition to wait before moving into an intersection when the light turns green. As the light turns, a speeding car, that they did not see, runs a red light. By following the premonition an accident is avoided. Another person may wake up in the middle of the night and see a loved one at the foot of their bed. They find out the next day that the person died at the time when they saw them, even though they were physically many miles away. Because these experiences can not be cultivated, there are no practices that can bring them about in the hospital. However, it is important to realize that these events do sometimes happen and they can be a source of significant strength to patients during trying times.

Mystical Spiritual Experience

This spiritual state transcends any physical image. It may be experienced as moments of intense focus, clarity, bliss or union with the divine.

20

People who connect with the divine in a mystical experience may feel as if they are momentarily engulfed in something that can best be described as an alternate reality. For example, when athletes feel that they are "in the zone" they may be having this type of spiritual experience. Times of meditation or prolonged spiritual practice may bring on a sense of profound joy or overwhelming compassion for the world. At other times, someone may comprehend universal truths or grasp complex issues in a flash of insight beyond their normal level of understanding.

Mystical Spiritual Experience

- Use of Mystical Experience
  - Time of silence
  - Meditation
  - Breathing techniques
  - Chant
  - Brain wave music

21

Some mystical experiences are spontaneous, but spiritual practices that promote this spiritual experience are sitting in silence or focusing intently on sensations or sounds as a way to bring consciousness to the moment. There are a wide variety of meditation techniques that facilitate the capacity for mystical experience and the patient can tell you if a particular practice is helpful. There is currently music and chanting available on CD to facilitate the brain wave changes that are experienced during mystical experiences that may be used by patients to facilitate relaxation or meditation.

Spiritual Interventions

- Prayer
- Scripture/sacred readings
- Music
- Meditation
- Guided imagery
- Life review
- Reconciliation
- Grief work

22

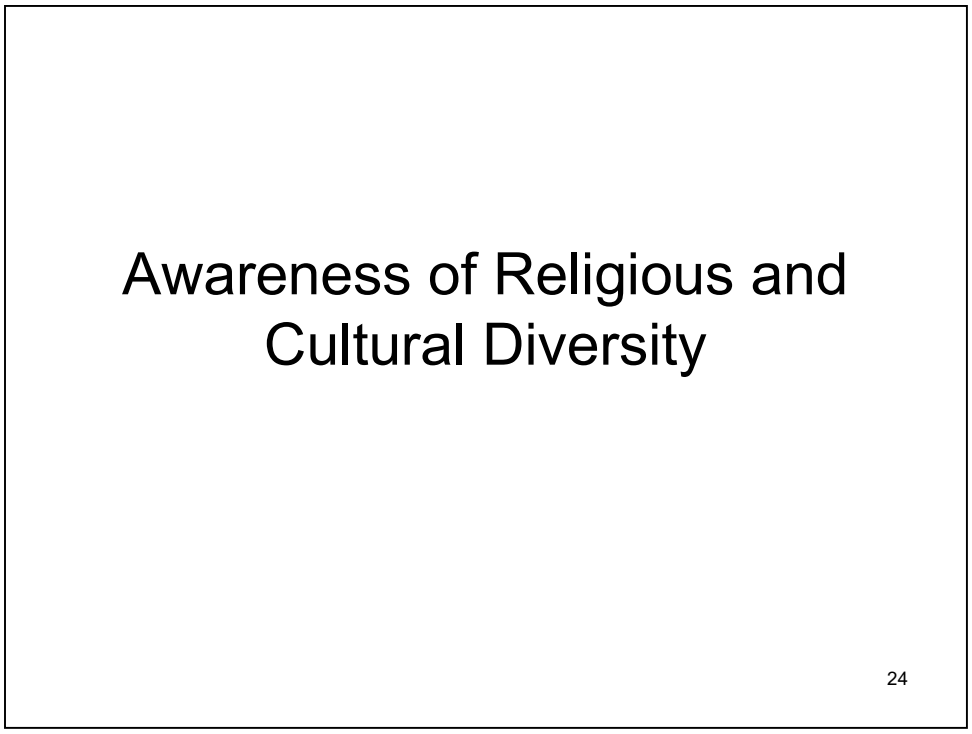
There are a variety of helpful interventions that may be used by patients with religious or non-religious backgrounds. It is always important that a prayer, sacred reading or guided imagery be relevant for the patient. It is not appropriate for a caregiver to use the position of patient dependency to impose one's own religious beliefs or spiritual background upon patients. Offer things that are meaningful for the patient in their own spiritual expression. If you are not sure about an intervention, ask the patient or family about what works for them. You can also always call for assistance from the chaplain.

There are several common states of spiritual experiences that one may encounter with patients: Nature, Concrete Image, Phenomena, and Mystical.

By recognizing that there are different types of spiritual experience, one can offer interventions that are more likely to assist the patient and facilitate healing.

23

From this presentation you may be able to recognize spirituality that is similar to your own and recognize some forms that may be different from your own experiences. By listening for different types of spiritual experiences, you will be more effective in helping patients make use of their own spiritual practices to facilitate healing in both physical and emotional levels.



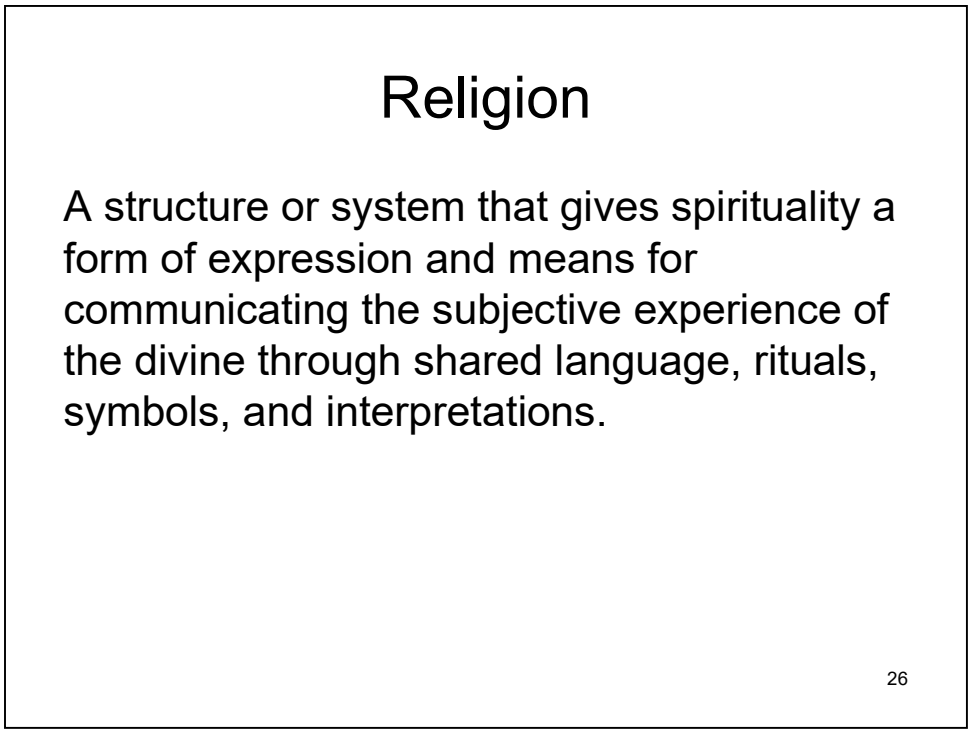
This is the third section of this presentation designed to assist healthcare workers in becoming more comfortable with the diverse patients in their care. This session will deal with cultural and religious diversity.

Objectives for Part 3

- Increase awareness of religious and cultural diversity in patient care
- Identify ways to approach diverse patients and families

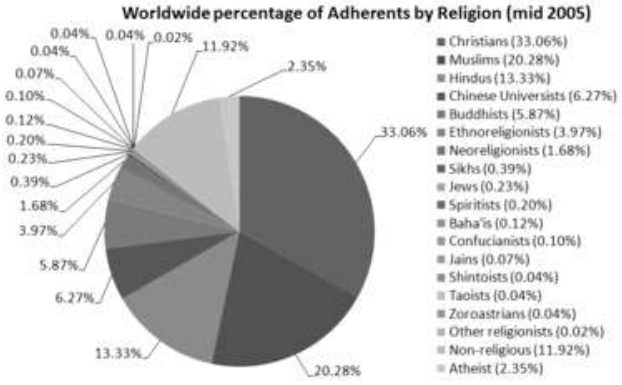
25

At the end of this session you will be able to recognize some of the ways that culture and religion affect the way you perceive the world and some of the ways that culture and religion have shaped the way patients and their families see the world. You will learn how to cultivate greater sensitivity to cultural differences in order to meet the cultural and religious needs of those in your care.



Religion provides a means for people to communicate their spiritual life and find a community where their spiritual experiences make sense. In contemporary society there is an increased awareness of the variety of religions and our patients increasingly represent the religious diversity of the larger world.

World-wide Religious Practice



From Wikipedia[27]

In this visual representation of religious practice in the world we see that 85% of the world's population claim a religious tradition. Within our patient population we see a higher percentage of Christians and Jews than is represented in the world population. Because of our location, we see a higher percentage of ethno-religionists and neo-religionists than are represented here. Increasingly, we are encountering Muslims, Hindus, and Buddhists and other religions in our daily work.

Religious Expression

- Some non-affiliated religious groups
  - Alcoholics Anonymous
  - Spiritual seeker groups
  - Prayer/meditation groups

28

In the United States and in Arizona we have several non-affiliated religious groups that could be classified among the "non-religious". These may be those people who classify themselves as "spiritual but not religious". These groups may fulfill the same sense of community that belonging to a faith community fills for others.

Helpful Aspects of Religion

- Frequently promotes healthy lifestyle
- Provides a social structure to support patient and family in times of illness
- Encourages trust and hope that can impact patient's response to treatment
- May help patient and family make meaning out of tragedy and illness

29

Studies by Harold Keonig, David Larson, Herbert Benson and others have demonstrated that there are some ways in which religious practice is helpful in the healing process. The belief structure and sense of community provide support that seems to give religious patients a statistically significant edge over non-religious patients in their ability to cope with illness and in their ability to recover.

Unhelpful Aspects of Religion

- Families may be divided religiously and bring different value systems into healthcare decisions
- May foster dependence to the extent that it promotes a helpless attitude
- May foster distrust or disrespect for those outside of religious group
- May deny reality of domestic violence or child abuse

30

It is also important to recognize that there are also some aspects of religion that can be detrimental to healing. Some religious groups rigidly define membership and are distrustful of those outside of their group. This can foster an antagonistic relationship with healthcare providers if there is a medical recommendation that violates a religious value. If you become aware that the religious beliefs are causing challenges with the patients care, please make use of the Spiritual Care Department to assist you in developing a plan of care that addresses these challenges.

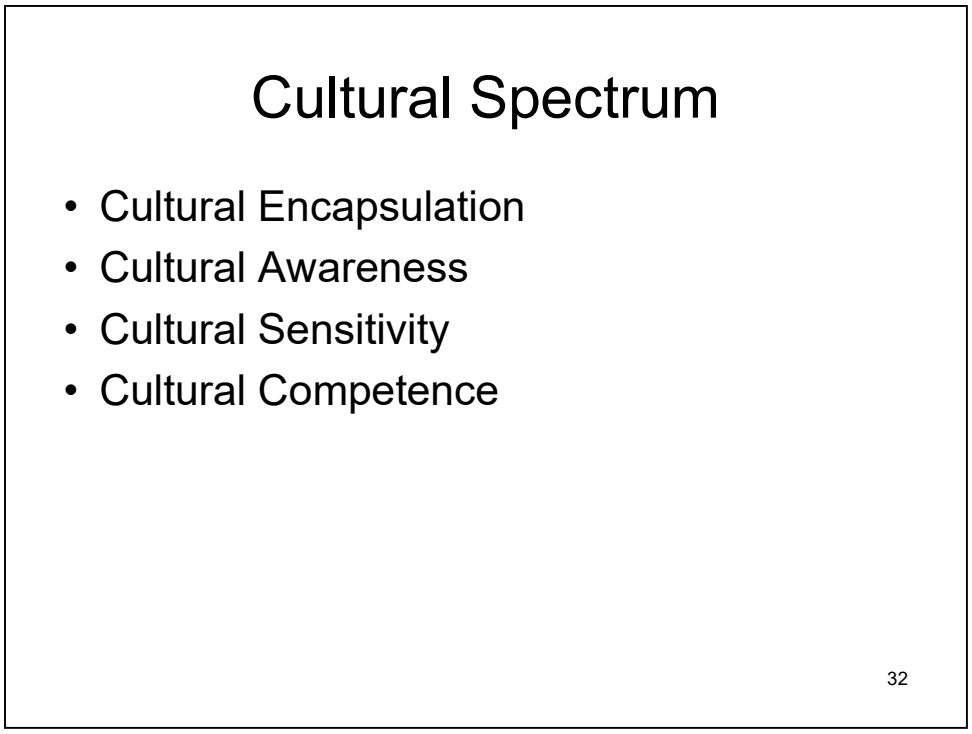
Culture

- A learned pattern of behavior that is a logically integrated, functional, sense making whole; is dynamic and in a constant state of change; is transacted through symbols;* and involves a shared system of interaction

David Augsburger, *Pastoral Counseling Across Cultures*

31

Looking at culture in a broad way we can see that culture may be defined by ethnicity or country of origin but may equally be defined by a religious or family structure.



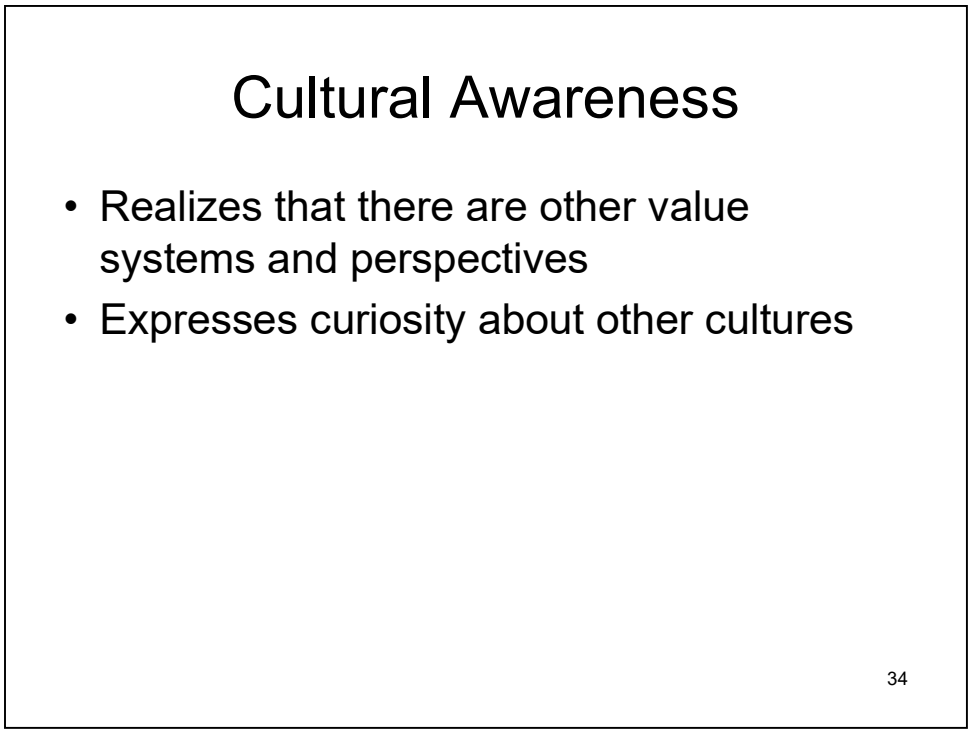
In order to avoid an overly simplified view of cultural diversity and to avoid creating more stereotypical perspectives, we will look at different levels of openness to diversity. The more culturally open we are, the less likely we are to inadvertently insult or neglect someone from a different culture. Our hope is to encourage cultural sensitivity in ourselves and become more able to achieve moments of cultural competence in our work with people who have different value systems and beliefs.

Cultural Encapsulation

- Unaware of own cultural norms
- Assumes that most people share the same values and perspectives
- While one may be hostile toward differences between people, for the most part, reactivity is from lack of awareness

33

Cultural encapsulation is the state of mind that is not aware that others have different ways of doing things. There may be a sense of cultural superiority in this stance, but often where one is culturally encapsulated, one is not aware that there are other value systems. Unless one has lived for an extended time in a different culture, most of us have some areas where we are culturally encapsulated. For example, a man buys a custom made suit in Italy and is given the price in lira. He asks the tailor how much it costs in "real money". Understanding one's own customs, monetary systems or political structure as the only valid norm are all forms of cultural encapsulation.



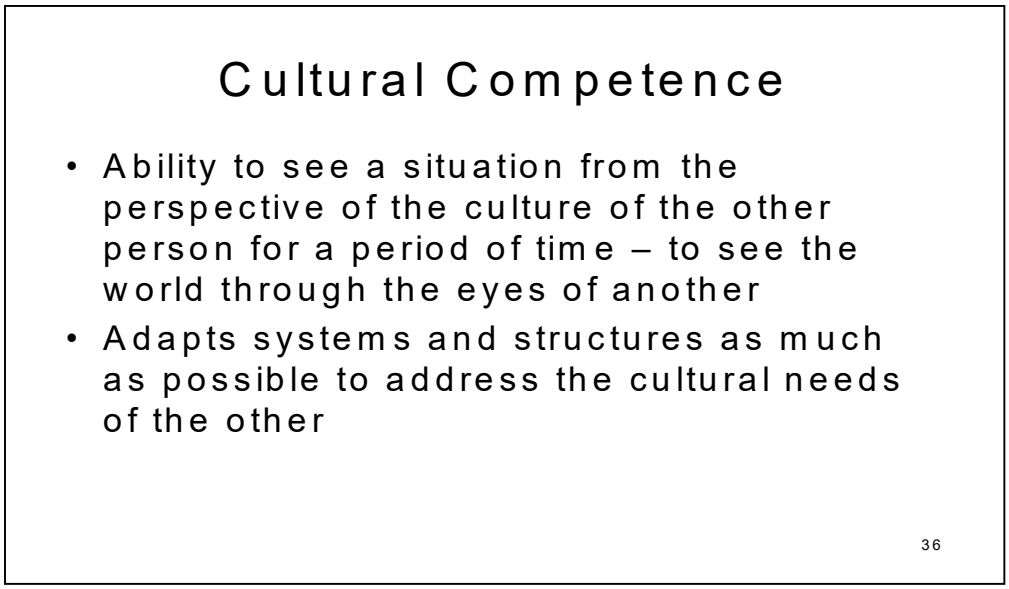
As one becomes culturally aware, one recognizes that others have different customs, holidays, family structures and ways of accomplishing tasks. In this state of awareness, one may be open to the differences or may be critical of different value systems. It is important to realize that recognizing different value systems does not mean that one abandons their own value system in favor of another. Just realize that there is a logical structure supporting a different cultural expression and you can appreciate the difference without letting go of your own culture.

Cultural Sensitivity

- Beginning to understand the values and perspectives of other cultures
- Able to engage those of other cultures in a caring way in order to address their unique needs
- Knows enough to realize that one can never fully know another culture

35

As one moves into cultural sensitivity, one begins to take an active role to understand someone from a different background. The culturally sensitive caregiver treats everyone with respect. When working with a patient or family from a different culture, this caregiver looks for ways to allow the patient to be as comfortable as possible in the strange culture of the hospital. This may mean finding ways for the family to bring in ethnic foods that are important to the patient, going the extra mile to respect the patient's need for a caregiver of the same sex, making room for extended family to visit, or contacting a cultural healer to provide healing ceremonies. This does not mean that you violate good medical practice, but it does mean that you honor the patient's cultural and religious background in making a plan of care.



It is unlikely that most of us will reach full cultural competence. Someone can live in a different culture for twenty years and still not have the full awareness of a particular culture. Perhaps we can, however, attempt to see the situation from the patient's perspective on occasion. This calls upon us to pay close attention to the unique characteristics of a patient and their family and requires that we listen as they tell us about their experiences. In New Zealand, the hospitals have large family centers nearby so that the Maori patient families can be present during illness. In the Maori culture the whole extended family is present to support the patient and immediate family during an illness. The hospital system was adapted to address this cultural need and make a way for Maori patients to continue to participate in their culture while ill. We are a long way away from this level of cultural competence; however, there may be ways that we can work with our system to make our hospital more sensitive and respectful of our patient's cultural needs. One floor here went the extra mile to work with a patient who wanted her room smudged before she was admitted for surgery. The staff got clearance for smudging from safety and made sure that smoke did not get

Developing Cultural Sensitivity

- Recognize one's own religious and cultural assumptions
- Expect that others have different assumptions and experiences
- Take an attitude of a student and let the patient teach you

37

Those of us in the healthcare professions have a strong desire to help others. By understanding and respecting the different cultural and religious needs of patients, we are more likely to be of help to them. It is very important to recognize that we have our own value judgments and cultural assumptions. There is nothing wrong with that. As we recognize where our values and assumptions are different that others, we can take a position where we allow the patient to help us understand what is important to them and how we can best serve them within their own cultural value system.

Developing Cultural Sensitivity

- Remember that you have common ground
- Recognize the value of cultural patterns
- Avoid stereotypical generalizations about members of a cultural group

38

No matter how different a patient is from you, remember that you still have a lot in common with them. Although there are different culturally appropriate expressions of emotions, everyone experiences fear, sadness, grief, and joy. Everyone appreciates being treated with courtesy and respect. Remember that a patient's cultural and religious background can give them important support and stability in the middle of a health crises. Also, remember that you may understand about a particular cultural group but that does not mean that a patient from that group will follow all of the cultural norms of that group. Even members of the same family will have personality differences that will impact how they embrace or do not embrace different elements of their culture.

Some areas Requiring Cultural Sensitivity

1. Family structure – decision making
2. Sense of personal space
3. How to talk with those outside of the family (including eye contact, volume of speech, questions, interruptions, who can talk with those in authority)
4. How to address major life transitions
5. Dietary and hygiene needs

39

While there are large areas of cultural differences, within the hospital setting, you can avoid many cultural missteps by paying attention to these areas which are shaped by culture. Notice how the patient defines who makes up their family and who in the family has the ability to make decisions. It may be the patient, or there may be a family designate. If someone other than the patient is responsible for healthcare decisions, include that person in discussions about treatment. Notice how the patient and family members react to touch and where their comfort level is with personal space. Remember that many cultures consider it rude to give too much direct eye contact or to interrupt or question an authority figure. It is often helpful to make a clear opportunity for patients or family members to have time to ask questions or share their concerns with you.

When in Doubt

- Let the patient and family be your guide
- Ask how the patient and family want an issue addressed
- Make use of the Spiritual Care Department or Language and Cultural Services

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There may be many times when these guidelines will not address a specific concern you have with a culturally different patient or family. If you make it clear that you want to know how to best serve them, most patients and families will appreciate it if you ask how they want you to address their concern. Also, you can call upon the resources of the Spiritual Care Department or Language and Cultural Services. We may not have all of the answers, but we will help you and the family by finding out who does have the answers. Together we can make the hospital a more welcoming environment for all of our patients and their families.

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